Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PROPOSED

PUBLIC NOTICE

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services - Mental Health Services

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), 42 CFR §447.205, and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Delaware Title XIX Medicaid State Plan regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, specifically, *coverage and reimbursement methodologies for rehabilitative mental health services*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Glyne Williams, Planning, Policy and Quality Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by December 1, 2015. Please identify in the subject line: EPSDT – Mental Health Services.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposes to amend the Title XIX Medicaid State Plan regarding the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, specifically, *coverage and reimbursement methodologies for rehabilitative mental health services*.

Statutory Authority

- Section 1905(r) of the Social Security Act, *Early and Periodic Screening, Diagnostic, and Treatment Services*
- 42 CFR §441 Subpart B, *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) of Individuals under Age 21*
- 42 CFR §440.60, *Medical or other remedial care provided by licensed practitioners*
- 42 CFR §440.130, *Diagnostic, screening, preventive, and rehabilitative services*
- 42 CFR §447.205*, Public notice of changes in statewide methods and standards for setting payment rates*
- State Medicaid Manual, Section 5010, *Early and Periodic Screening, Diagnostic, and Treatment Services*

Background

Early and Periodic Screening, Diagnostic, and Treatment Services

The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic, and Treatment services, or EPSDT. Under federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act], EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the Delaware Medicaid State Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act].

States have an affirmative obligation to make sure that Medicaid-eligible children and their families are aware of EPSDT and have access to required screenings and necessary treatment services. States also have broad flexibility to determine how to best ensure such services are provided. In general, they either administer the benefit outright (through fee-for-service arrangements) or provide oversight to private entities with whom they have contracted to administer the benefit (e.g., managed care entities). States must arrange (directly or through delegations or contracts) for children to

receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.

Medicaid Rehabilitative Services

Treatment for mental health and substance use issues and conditions is available under a number of Medicaid service categories, including hospital and clinic services, physician services, and services provided by a licensed professional such as a psychologist. States should also make use of rehabilitative services. While rehabilitative services can meet a range of children's treatment needs, they can be particularly critical for children with mental health and substance use issues. Rehabilitative services are defined to include:

> *any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.*

Like other services covered under EPSDT, rehabilitative services need not actually cure a disability or completely restore an individual to a previous functional level. Rather, such services are covered when they ameliorate a physical or mental disability, as discussed above. Moreover, determinations of whether a service is rehabilitative must take into consideration that a child may not have attained the ability to perform certain functions. That is, a child's rehabilitative services plan of care should reflect goals appropriate for the child's developmental stage.

Depending on the interventions that the individual child needs, services that can be covered as rehabilitative services include:

- Community-based crisis services, such as mobile crisis teams, and intensive outpatient services;
- Individualized mental health and substance use treatment services, including in non-traditional settings such as a school, a workplace or at home;
- Medication management;
- Counseling and therapy, including to eliminate psychological barriers that would impede development of community living skills; and
- Rehabilitative equipment, for instance daily living aids.

With respect to the provision of rehabilitative services, including those noted above, CMS requires more specificity of providers and services due to the wide spectrum of rehabilitative services coverable under the broad definition. CMS would expect a state to include in their State Plan the services, and providers with their qualifications, as well as a reimbursement methodology for each service it provides.

Summary of Proposal

Note: This Mental Health Services state plan amendment (SPA) is first of three (3) proposed SPA actions related to Medicaid rehabilitative services for individuals under age 21 to clarify coverage and payment methodology under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Purpose

The purpose of this notice is to clarify service descriptions, reimbursement methodologies, and provider qualifications for rehabilitative mental health services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) State Plan and to request comments from the public.

On February 23, 2011, the Centers for Medicare and Medicaid Services (CMS) sent a companion letter to the Division of Medicaid and Medical Assistance (DMMA) concerning a previously approved State Plan Amendment #08-004, School-Based Health Services. CMS performed a program analysis of corresponding coverage sections not originally submitted with this SPA. This analysis revealed concerns regarding the monthly bundled rates for rehabilitative child mental health and substance use disorder services under the EPSDT program. CMS determined that the service descriptions and reimbursement language for rehabilitative child mental health and substance use disorder services fails to comply with 42 CFR 430.10 and 42 CFR 447.252 which implement in part Section 1902(a)(30)(A) of the Social Security Act, to require collectively that States comprehensively describe the methodologies that they use to reimburse service providers. The methodologies must be understandable, clear, unambiguous, and auditable.

Proposal

In order to comport with 42 CFR 430.10 and 42 CFR 447.252, DMMA proposes to clarify existing rehabilitative mental health services and reimbursement methodology language currently described at Attachment 3.1-A and Attachment 4.19-B in the Delaware Medicaid State Plan by:

- defining the reimbursable unit of service;
- describing payment limitations;
- providing a reference to the provider qualifications per the State Plan;
- publishing location to access State developed fee schedule rates.

The agency's proposal involves no change in the definition of those eligible to receive mental health services benefit under the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, and the mental health services benefit available to eligible recipients remains the same.

Summary of Proposed Changes

The proposed Medicaid Rehabilitative Mental Health Services SPA clarifies coverage for outpatient and residential mental health services for children under the Medicaid program including care by unlicensed practitioners and Evidence-Based Practices (EBPs). If implemented as proposed, the coverage and reimbursement methodology plan amendments will accomplish the following, effective July 1, 2016:

Crisis intervention for children, unlicensed mental health practitioners (including Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, and family peer support services) and all residential programs providing children's mental health services to reflect the current rehabilitative services not covered under other Medicaid authorities. The rates for these services will be set using the same modeled rate methodology as the Division of Substance Abuse and Mental Health (DSAMH) PROMISE *(Promoting Optimal Mental Health for Individuals through Supports and Empowerment)* fee schedule for unlicensed practitioners and programs. The rates may vary from PROMISE depending upon the need for adaptions to the rates for accessibility of services by children and differences in service delivery.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the *state* public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input to the methods and standards governing payment methodology for rehabilitative mental health services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Comments must be received by 4:30 p.m. on December 1, 2015.

CMS Review and Approval

The provisions of this draft state plan amendment (SPA) are subject to the Centers for Medicare and Medicaid Services (CMS) review and approval. The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manual Update

Also, upon CMS approval, the applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates.

Fiscal Impact Statement

The purpose of this state plan amendment is to update and reorganize both the services (Attachment 3.1-A) and reimbursement (Attachment 4.19-B) sections of the Medicaid State Plan that primarily address rehabilitative services early and periodic screening, diagnostic, and treatment (EPSDT) program.

This amendment is not for the purpose of making program changes. Rather, this is part of DHSS/DMMA's continuing effort in working with CMS to assure the reimbursement pages clearly correspond to the service sections of the state plan and to implement the required wording regarding fee schedules and the dates for which reimbursement rates were set for these services. There are no intended content changes other than improved descriptions.

The proposed amendment imposes no increase in cost on the General Fund as the proposed services in this State plan amendment will be budget neutral.

Federal budget impact for federal fiscal years 2016 and 2017 is projected as follows:

Federal Fiscal Year 2016	Federal Fiscal Year 2017
$195,802.39	$837,865.32

DMMA PROPOSED REGULATION #15-21a
REVISION:

State/Territory: Delaware

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

With the exception of the EPSDT screens, all services covered under this section shall be medically necessary and shall be prescribed in a written treatment plan signed by a licensed practitioner within the scope of practice as defined under state law or regulations and documented in the student's IEP/IFSP. Services must be performed by qualified professionals operating within the scope of their practice under State law and regulations. The services described below, which are delivered by school providers, are also available in the community from other providers.

Services must be provided by qualified providers who meet the requirements of the regulations cited above in this section and other applicable state law and regulations as per 42 CFR 440.60. Unlicensed professionals may operate under the direction of a licensed practitioner who acts as supervisor and is responsible for the work, plans the work and methods, who regularly reviews the work performed and is accountable for the results. Supervision must adhere to the requirements of the practitioner's applicable licensing board. The licensed practitioner must co-sign documentation for all services provided by practitioners under his or her direction.

Providers must maintain all records necessary to fully document the nature, quality, amount and medical necessity of services furnished to Medicaid recipients.

~~3)~~ ~~Mental Health and Drug/Alcohol services approved and monitored through the Department of Services for Children, Youth and their Families. These include:~~

- ~~(a) Mental Health Outpatient Services~~
- ~~(b) Mental Health Case Management~~
- ~~(c) Professional Medical Services (i.e., neurologists, clinical psychologists, psychiatric social workers and other licensed medical providers)~~
- ~~(d) Psychiatric facility services~~
- ~~(e) Drug/Alcohol Rehabilitation Services.~~

DMMA PROPOSED REGULATION #15-21b
REVISION:

Attachment 3.1-A
Page ~~2c~~ 2d Addendum

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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

~~4)~~ 3) Medical Equipment and Supplies per 42 CFR 440.70

~~5)~~ 4) Orthotics and Prosthetics

~~6)~~ 5) Chiropractic Services

~~7)~~ ~~Any other medical or remedial care provided by licensed medical providers as authorized under 42 CFR 440.60. Unlicensed professionals may operate under the direction of a licensed practitioner who acts as supervisor and is responsible for the work, plans the work and methods, who regularly reviews the work performed and is accountable for the results. Supervision must adhere to the requirements of the practitioner's applicable licensing board. The licensed practitioner must co-sign documentation for all services provided by practitioners under his or her direction.~~

~~8)~~ 6) Any other services as required by §6403 of OBRA '89 as it amended §1902(a)(43), §1905(a)(4)(B) and added a new §1905(r) to the Act.

DMMA PROPOSED REGULATION #15-21c
REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d)

The following explanations apply to all rehabilitative services, which include the following services:

- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation
- Crisis Intervention
- Family Peer Support Services
- Rehabilitative Residential Supports

These rehabilitative services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children with significant functional impairments resulting from an identified mental health and/or substance abuse diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed behavioral health practitioner or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

Service Utilization:

Services are subject to prior approval, must be medically necessary and must be recommended by a licensed mental health practitioner or physician according to an individualized treatment plan. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the licensed behavioral health practitioner or physician responsible for developing the plan with the individual (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the individual, family and providers and include a reevaluation of the plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services.

Any entity providing Substance Use Disorder (SUD) treatment services must be certified by Delaware Health and Social Service (DHSS) or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Delaware. Providers must maintain medical records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitative services provided, and progress made toward functional improvement and goals in the treatment plan. Any practitioner providing behavioral health services must operate within an agency licensed, certified or designated by DHSS or its designee.

Medical necessity of the services is determined by a licensed behavioral health practitioner or physician conducting an assessment consistent with state law, regulation and policy. Services provided at a work site must not be job task-oriented and must be directly related to treatment of an individual's behavioral health needs. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, child care, laundry or basic services for the convenience of a person receiving covered services are non-covered. Services cannot be provided in an institution for mental disease (IMD). Room and board is excluded from any rates provided in a residential setting. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHSS or its designee.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the individual's medical record. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.

The services are defined as follows:

1. Community Psychiatric Support and Treatment (CPST) are goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's individualized treatment plan. CPST is a face-to-face intervention with the individual, family or other collaterals with all treatment and activities related directly to goals on the Medicaid beneficiary's rehabilitation treatment plan. CPST contacts may occur in community or residential locations where the person lives, works, attends school, and/or socializes.

This service may include the following components:

A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

1. Community Psychiatric Support and Treatment (CPST) Continued

B. Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.

C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.

D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk the individual remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

E. Restoration, rehabilitation and support to develop skills to locate, rent and keep a home; landlord/tenant negotiations; selecting a roommate and renter's rights and responsibilities.

F. Assisting the individual to restore and enhance rehabilitative daily living skills including:

- Coping with and managing psychiatric symptoms, trauma and substance use disorders;
- Promoting wellness and recovery support;
- Learning to independently navigate the service systems;
- Setting personal goals; and

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

1. Community Psychiatric Support and Treatment (CPST) Continued

- Enhancing community living skills specific to managing their own home including managing their money, medications, and using community resources and other self care requirements;
- Enhance resiliency/recovery-oriented attitudes such as hope, confidence and self-efficacy;
- Improving Self-Advocacy, Self-Efficacy & Empowerment skill building to -
  - Develop, link to and facilitate the use of formal and informal resources, including connection to peer support groups in the community;
  - Serve as an advocate, mentor or facilitator for resolution of issues; and,
  - Assist in navigating the service system.

Provider qualifications: Must have a Bachelor of Arts/Bachelor of Science (BA/BS), Master of Arts/Master of Science (MA/MS) or doctorate degree in social work, counseling, psychology or a related human services field to provide all aspects of CPST including counseling. Other aspects of CPST except for counseling may otherwise be performed by an individual with BA/BS degree in social work, counseling, psychology or a related human services field or four years of equivalent education and/or experience working in the human services field. Certification in the State of Delaware to provide the service includes criminal, professional background checks, and completion of a state approved standardized basic training program.

Service Utilization: Caseload size must be based on the needs of the individuals/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual's treatment plan. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a physician, nurse practitioner or licensed behavioral health practitioner (LBHP) as defined in 3.1-A Page 3 Addendum with experience regarding this specialized mental health service.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

2. Psychosocial Rehabilitation (PSR) Services are designed to assist the individual compensate for or eliminate functional deficits and interpersonal and/or environmental barriers associated with his or her mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The structured, scheduled activities provided by this service emphasize

the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting his or her personal life goals and to support his or her transition into adulthood. PSR is a face-to-face intervention with the individual present with all activities directly related to goals on the Medicaid individual's rehabilitation treatment plan. Services may be provided individually or in a group setting. PSR contacts may occur in community or residential locations where the individual lives, works, attends school, and/or socializes. PSR components include:

A. Restoration, rehabilitation and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and promote effective functioning in the individual's social environment including home, work and school.

B. Restoration, rehabilitation and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with the individual's daily living. Supporting the individual with enhancement and implementation of rehabilitative daily living skills and daily routines critical to remaining in home, school, work, and community.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

2. Psychosocial Rehabilitation (PSR) Services Continued

C. Assisting with the implementation of daily living skills so the individual can remain in a natural community location.

D. Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider Qualifications: Must be at least 21 years old, and have a high school diploma or equivalent. Additionally, the provider must be at least three (3) years older than an individual under the age of 18 years. Certification in the State of Delaware to provide the service includes criminal, professional background checks, and completion of a state approved standardized basic training program.

Service Utilization: Prior authorization is required for all services. This authorization can be exceeded when medically necessary through prior authorization. The PSR provider must receive regularly scheduled clinical supervision from a professional meeting the qualifications of a physician, nurse practitioner or licensed behavioral health practitioner (LBHP) as defined in 3.1-A Page 3 Addendum with experience regarding this specialized mental health service.

3. Crisis Intervention (CI) services are provided to an individual who is experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Crisis Intervention are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential, or actual, or perceived psychiatric crisis.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

3. Crisis Intervention Services Continued

Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the individual lives, works, attends school, and/or socializes.

Activities include:

A. A preliminary assessment of risk, mental status, and medical stability and the need for further evaluation or other behavioral health services. Includes contact with the client, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.

B. Short-term crisis interventions including crisis resolution and de-briefing with the identified Medicaid eligible individual.

C. Follow-up with the individual, and as necessary, with the individual's caretaker and/or family members.

D. Consultation with a physician or with other qualified providers to assist with the individual's specific crisis.

Provider Qualifications: Must be at least 21 years old and have an Associate of Arts/Associate of Science (AA/AS) degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. Additionally, the provider must be at least three (3) years older than an individual under the age of 18. Certification in the State of Delaware to provide the service, which includes criminal and professional background checks, and completion of basic training in topics including recovery resiliency, cultural competency, safety, care coordination, risk management and suicide prevention, post-intervention, person-centered care, and de-escalation techniques.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

3. Crisis Intervention Services Continued

The assessment of risk, mental status, and medical stability must be completed and/or approved with care recommended by a physician, nurse practitioner or licensed behavioral health practitioner (LBHP) as defined in 3.1-A Page 3 Addendum with experience regarding this specialized mental health service, practicing within the scope of his or her professional license. This assessment and recommendation is billed separately by the physician, nurse practitioner, or licensed behavioral health practitioner (LBHP) per 3.1-A Page 3 Addendum.

Service Utilization: All individuals who self-identify as experiencing a seriously acute psychological/ emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care. The crisis plan developed by the unlicensed professional from the assessment and all services delivered during a crisis must be provided under the supervision of a physician, nurse practitioner, or licensed behavioral health practitioner (LBHP) as defined 3.1-A Page 3 Addendum with experience regarding this specialized mental health service and as such must be available at all times to provide back up, support, and/or consultation. Crisis services may require a medical clearance if substance use is suspected to ensure that the individual is not a danger to himself or others.

Crisis Intervention – Emergent is authorized up to (six) 6 hours per episode.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

Crisis Intervention – Ongoing is authorized up to seventy-two (72) hours per episode. An episode is defined as the initial face to face contact with the individual until the current crisis is resolved, not to exceed seventy-two (72) hours without prior authorization by DHSS or its designee. The individual's chart must reflect resolution of the crisis, which marks the end of the current episode. If the individual has another crisis within seven (7) calendar days of a previous episode, it shall be considered part of the previous episode and not a new episode. Initial authorization can be exceeded when medically necessary through prior authorization.

4. Family Peer Support Services (FPSS) are an array of formal and informal services and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/ family member/caregiver for the benefit of the child/youth.

Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together or those with a significant relationship outside the home, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/care-giving for the child(ren).

Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's treatment plan. FPSS is a face-to-face intervention, recommended by a physician, nurse practitioner or licensed behavioral health practitioner (LBHP), operating within the scope of his or her practice with the child, family/caregiver or other collateral supports.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

4. Family Peer Support Services Continued

FPSS can be provided through individual and group face-to-face contact and can occur in a variety of settings including community locations where the individual lives, works, attends school, engages in services and/or socializes. Components of FPSS include:

A. Outreach and Information: Empower families to make informed decisions regarding the nature of supports for themselves and their child.
B. Engagement, Bridging and Transition Support: Provide a bridge between families and service providers, support a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
C. Self-Advocacy, Self-Efficacy and Empowerment: Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
D. Parent Skill Development: Support the efforts of families in caring for and strengthening their child(ren)'s mental health, physical health, development and well-being.
E. Community Connections and Natural Supports: Enhance the quality of life by supporting the integration of families into their own communities.

Provider Qualifications: A Certified Peer is an individual who has self-identified as a beneficiary or survivor of mental health and/or substance use disorder (SUD) services, is at least 21 years of age, and meets the qualifications set by the state including specialized peer specialist training, certification and registration. The training provided/contracted by DHSS or its designee shall be focused on the principles and concepts of peer support and how it differs from clinical support.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

4. Family Peer Support Services Continued

The training will also provide practical tools for promoting wellness and recovery, academic information on recovery and resiliency, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. A Certified Peer must have at minimum a high school education or General Educational Development (GED) (preferably with some college background) and be currently employed as a peer supporter in Delaware. Each crisis program including certified peer staff is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable state law.

A Certified Recovery Peer Advocate is certified by DHSS or its designee. Recovery coaches must be trained and certified in the State of Delaware to provide services. The certification includes criminal, abuse/ neglect registry and professional background checks, and completion of a State-approved standardized basic training program.

Certified Peers may be utilized under clinical supervision for the activities of crisis resolution and debriefing with the identified Medicaid child's family/caregiver. A candidate with provisional credentials may provide this service while completing certification.

Supervisor Qualifications:

- The FPSS provider must receive regularly scheduled supervision from a competent mental health professional meeting the qualifications of either:
  - a professional meeting the qualifications of a Licensed Behavioral Health Practitioner (LBHP) as defined in 3.1-A Page 3 Addendum or
  - a FPSS supervisor who is an individual working as a certified peer for a minimum of five (5) years, in which two (2) years should have been as a credentialed peer advocate or its equivalent including specialized training and/or experience as a supervisor.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

4. Family Peer Support Services Continued

- The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.
  - Supervision of these activities may be delivered in person or by distance communication methods. It is the expectation that one (1) hour of supervision be delivered for every forty (40) hours of Family Peer Support Services duties performed.
  - There may be an administrative supervisor who signs the FPSS's timesheet and is the primary contact on other related human resource management issues.

Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

The practitioner must have training in the general training requirements required by DHSS or its designee.

The caseload size must be based on the needs of the individuals/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

Amount, Duration and Scope: A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHSS or its designee.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment (RRT) provides a community-based rehabilitative residential supports in a setting of no greater than sixteen (16) beds under the supervision and program oversight of a licensed behavioral health practitioner (LBHP) including Psychiatrists, Physicians, Advanced Registered Nurse Practitioners, Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors of Mental Health, and Licensed Marriage and Family Therapists). The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to return to and remain successfully in his/her home and community, and to regularly attend and participate in work, school or training. RRTs deliver rehabilitative supports through an array of clinical and related activities including psychiatric supports, integration with community resources and skill-building. RRT treatment must target reducing the severity of the behavioral health issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts).

Treatment must:

- Focus on reducing the behavior and symptoms of the psychiatric and/or behavioral disorder that necessitated the removal of the child or adolescent from his/her usual living situation.
- Decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement.
- Transition child or adolescent from RRT to home or community based living with outpatient treatment (e.g., individual and family therapy) including generalizing skills learned in the RRT setting.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

RRT programs are organized and staffed to provide both general and specialized residential (e.g., non-institutional, non-hospital) interdisciplinary services twenty-four (24) hours a day, seven (7) days a week for individuals with behavioral health disabilities or co-occurring disabilities. RRT services are organized to provide environments in which the individuals reside and receive services from personnel who are trained in the delivery of services for individuals with behavioral health disorders or related problems. RRT may be provided in freestanding, nonhospital-based facilities. RRTs may include nonhospital addiction treatment centers or other residential non-institutional settings.

The State Medicaid agency or its designee must have determined that less intensive levels of rehabilitative treatment are unsafe, unsuccessful or unavailable. The child must require active treatment that would not be able to be provided at a less restrictive level of care than is being provided on a twenty-four (24)-hour basis with direct supervision/oversight by professional behavioral health staff. The setting must be ideally situated to allow ongoing participation of the child's family with the exception of specialty facilities that are not available locally. The child or adolescent may attend a school in the community (e.g., a school integrated with children not from the group home and not on the grounds of the group home). Education services may be provided on site for those child and adolescents that cannot attend their community school.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

RRTs provide twenty-four (24) hours/day, seven (7) days/week structured and supportive living environment. However, Medicaid does not reimburse for supervision or room and board. Integration with community resources is provided to plan and arrange access to a range of educational and therapeutic services. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and twenty-four (24) hour medical availability, when appropriate and relevant. Screening and assessment is required to document and track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues. The individualized, strengths-based services and supports:

- Are identified in partnership with the child or adolescent and the family and support system, to the extent possible, and if developmentally appropriate;
- Are based on both clinical and functional assessments;
- Are clinically monitored and coordinated, with twenty-four (24) hour availability;
- Are implemented with oversight from a licensed mental health professional;
- Assist with the development of skills for daily living and support success in community settings, including home and school.

The RRT is required to coordinate with the child's or adolescent's community resources when possible, with the goal of transitioning the youth out of the program as soon as possible and appropriate. Discharge planning begins upon admission with concrete plans for the child to transition back into the community beginning within the first fifteen (15) days of admission with clear action steps and target dates outlined in the treatment plan. The treatment plan must include behaviorally-measurable discharge goals.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

For treatment planning, the program must use a standardized assessment and treatment planning tool. The specific tools and approaches used by each program must be specified in the program description and are subject to approval by the State. There is at least a quarterly review of client's treatment plan; goals and progress toward goals must be completed.

In addition, the program must ensure that requirements for pretreatment assessment are met prior to treatment commencing. RRT facilities may specialize and provide care for sexually abusive behaviors, substance abuse, or dually diagnosed individuals (e.g., either mental health/developmentally disabled or mental health/substance use disorder). If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed assessment and programming and training for the specialized treatment needs of the client.

For service delivery, the program must incorporate at least two (2) research-based approaches pertinent to the sub-populations of RRT clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description.

Provider Qualifications: A RRT must be accredited and licensed as residential treatment facility by DHSS or its designee and may not exceed sixteen (16) beds. RRT staff must be supervised by a licensed behavioral health practitioner (LBHP). Direct care staff must be at least 21 years old, and have a high school diploma or equivalent, certification in the State of Delaware or the state in which the facility is located to provide the service, which includes criminal, professional background checks, and completion of a state approved standardized basic training program.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

The program must have at least one (1) personnel member immediately available at all times who is trained in: First aid; Cardiopulmonary resuscitation (CPR); and the use of emergency equipment.

Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff when parents are available to participate in family therapy and to provide input on the treatment of their child.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set according to National Correct Coding Initiative guidelines.

Licensed psychologists and licensed behavioral health practitioners bill for their services separately under the approved State Plan for Other Licensed Practitioners.

A licensed behavioral health practitioner (LBHP), or other staff as required by the facility's accrediting body, must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The LBHP must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care in accordance with the requirements of their accrediting body. Although the LBHP does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and assure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention are required of RRTs, but provided and billed separately by licensed practitioners for direct time spent.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

RRTs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections when possible. Each child is given an opportunity to participate in community, social, recreational and spiritual activities as appropriate. The facility is expected to provide recreational activities for all enrolled children but not use Medicaid funding for payment of such non-Medicaid activities. Medicaid does not reimburse for room and board. In addition, each child is required to receive age-appropriate educational activities including the development of vocational skills and linkages to community resources even if such activities are not Medicaid reimbursable.

The RRT must ensure that medically necessary care not provided by the RRT including medical services and pharmaceutical services are provided without delay for the health of the child by appropriate providers in the community.

RRTs may not be Institutions for Mental Disease (IMD). Each organization owning RRTs must ensure in no instance does the operation of multiple RRT facilities constitute operation of an IMD. All new construction, newly acquired property or facility or new provider organization must comply with facility bed

limitations not to exceed sixteen (16) beds. Existing facilities may not add beds if the bed total would exceed sixteen (16) beds in the facility.

Discharge will be based on the child no longer making adequate improvement in this facility (and another facility is being recommended) or the child no longer having medical necessity at this level of care. Continued RRT stay should be based on a clinical expectation that continued treatment in the RRT can reasonably be expected to achieve treatment goals and improve or stabilize the child or adolescent's behavior, such that this level of care will no longer be needed and the child or adolescent can return to the community.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

Transition should occur to a more appropriate level of care (either more or less restrictive) if the child or adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care (e.g., child or adolescent's behavior and/or safety needs requires a more restrictive level of care, or alternatively, child or adolescent's behavior is linked to family functioning and can be better addressed through a family/home-based treatment).

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

The following explanations apply to all rehabilitative services, which are the following:
These rehabilitative services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children with significant functional impairments resulting from an identified mental health or substance abuse diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health practitioner or physician who is acting within the scope of his/her professional licensed and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level.

Service Utilization:

Services are subject to prior approval, must be medically necessary and must be recommended by a licensed mental health practitioner or physician according to an individualized treatment plan.The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitative strategy with revised goals and services.

Anyone providing addiction or mental health services must be certified by DHSS or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Delaware or the state in which the facility is located. Providers must maintain medical records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitative services provided, and progress made toward functional improvement and goals in the treatment plan.

Medical necessity of the services is determined by a licensed mental health practitioner or physician conducting an assessment consistent with state law, regulation and policy. Services provided at a work site must not be job tasks oriented and must be directly related to treatment of an individual's behavioral health needs. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a individual receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institution for mental disease (IMD). Room and board is excluded from any rates provided in a residential setting. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHSS or its designee.

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4.b. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the individual's medical record. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the Plan of Care. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.

DMMA PROPOSED REGULATION #15-21d
REVISION:

~~**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services**~~

~~Bundled Rates for Child Mental Health and Substance Abuse Services~~

~~A bundled rate is paid once each month for each Medicaid eligible recipient whose behavioral health treatment is clinically managed by the Department of Services for Children, Youth and their Families' (DSCYF's) Division of Child Mental Health (CMHI, and who has received at least one other qualifying mental health treatment service.~~

~~Inpatient behavioral health services for recipients under the age of 18 is managed by CMH. Outpatient services up to 30 units are covered in the managed care basic benefit package, and are the responsibility of the managed care organizations. The services included in the CMH bundled rate represent care which exceeds the initial 30 units per year, or is severe enough to require hospitalization or placement in a residential treatment center.~~

~~Mental health and substance abuse services provided by the Division of Youth Rehabilitative Services (YRS) or the Division of Family Services (DFS) are not clinically managed by CMH, and therefore currently are not included in the bundled rate reimbursement. Those services continue to be paid fee-for-service until DSCYF is able to bring them into the managed care network.~~

~~To develop the bundled rate, historic Medicaid billable costs are divided by Medicaid eligible member months. Billable costs include Administrative costs allocated to Medicaid at the State, department, and division levels, and Direct Service costs of Medicaid clients. Direct Service costs were calculated by multiplying the actual direct service portion of the fee-for-service Medicaid rates by the actual units of service provided to Medicaid eligible children in FY95. Medicaid eligible client months are determined by the assignment of the client to a CMH treatment team and the recording of a service paid by CMH. The cost and associated member months were removed from the data base for children who received 30 or fewer outpatient units or who would not meet the CMH criteria for clinical management. YRS and DFS clients receiving rehabilitative services which are not clinically managed by CMH are excluded from the bundled rate calculation.~~

~~DSCYF/Medicaid Services Included in the Bundled Rate~~

~~Psychiatric Hospital and JCAHO Accredited Residential Treatment~~
~~Non-accredited Residential Treatment~~
~~Treatment Family Homes~~
~~Mental Health Crisis Intervention~~
~~Mental Health Day Treatment~~
~~Mental Health Outpatient~~
~~Clinical Coordination~~
~~Assessment~~
~~Clinical Behavioral Guidance~~
~~Alcohol and Other Drug Accredited Residential Treatment~~
~~Alcohol and Other Drug Day Treatment~~
~~Alcohol and Other Drug Outpatient~~

~~Other behavioral health services as necessary to effectively treat the target population~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Rehabilitative Mental Health Services and Substance Use Disorder Services

Reimbursements for services are based upon a Medicaid fee schedule established by the Delaware Medical Assistance Program (DMAP).

The fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware *Register of Regulations*.

The Agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at http://www.dmap.state.de.us/downloads/feeschedules.html.

Attachment 4.19-B
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STATE:DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES CONTINUED

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Rehabilitative Mental Health Services and Substance Use Disorder Services Continued

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development:

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.