DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

FINAL

FINAL ORDER

Title XIX Reimbursement Methodology for Medicaid Services

Nature of the Proceedings:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA). The Department's proceedings to amend the Title XIX Medicaid State Plan to revise the reimbursement methodology for certain Medicaid services were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the June 2009 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by June 30, 2009 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary of Proposed Amendments

The purpose and effect of this proposal is to amend the Title XIX Medicaid State Plan to revise the reimbursement methodology for certain provider services to comply with proposed State budget legislation now under consideration.

Statutory Authority

- 42 CFR §440, Subpart A, Definitions;
- 42 CFR §447.205, Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates; and,
- 42 CFR §447, Payments for Services.

Background

Pursuant to 42 CFR §447.205, Delaware Health and Social Services (DHSS), Division of Medicaid and Medicaid Assistance (DMMA) is required to give public notice of any significant proposed change in its methods and standards for setting payment rates for services.

Summary of Proposed Amendments

As a result of a State budgetary shortfall and to remain within the available Medicaid appropriation, Delaware Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) has determined that it is necessary to amend the state plan provisions governing the reimbursement for medically necessary services provided to eligible recipients. This action is necessary to ensure no increase in State expenditures resulting from changes in reimbursement rates for the Delaware Medical Assistance Programs (DMAP).

Effective April 1, 2009, DHSS/DMMA intends to amend the applicable provisions of the Title XIX Medicaid State Plan governing the reimbursement methodology for certain services to reduce the reimbursement rate. In accordance with 42 CFR §440.205, public notice was published before the proposed effective date of the change on March 31, 2009 in the two newspapers of widest circulation in the State, the News Journal (New Castle County, Kent County, Sussex County) and, the Delaware State News (Kent County), as follows:

For periods beginning on and after April 1, 2009, the following provider rates will be "Rolled Back" or "Frozen" at their pre-January 1, 2009 level.

The following significant changes are proposed:

Inpatient Hospital Services:

Inpatient hospital discharge rates for General Acute Care Hospitals will be "rolled back" to their pre-January 1, 2009 level. Such reduction shall remain in effect until further notice.

Outpatient Hospital Services:

Outpatient hospital rates that are paid based on a hospital specific fee schedule will be "rolled back" to their pre-January 1, 2009 level. Such reduction shall remain in effect until further notice.

Private Nursing Facility Services:

Private nursing facility services rates will be "rolled back" to their pre-January 1, 2009 level. Such reduction shall remain in effect until further notice.

Pediatric Nursing Facility Services:

Pediatric nursing facility services rates will be frozen at their pre-April 1, 2009 level. Such change shall remain in effect until further notice.

Private Intermediate Care Facilities/Mentally Retarded (ICFs/MR):

Private ICFs/MR rates will be "rolled back" to their pre-January 1, 2009 level. Such reduction shall remain in effect until further notice.

Prescribed Pediatric Extended Care:

Prescribed Pediatric Extended Care services rates will be frozen at their pre-April 1, 2009 level. Such change shall remain in effect until further notice.

In addition, effective for dates of service on and after April 1, 2009, the following describes how these providers will be impacted by deferred implementation of inflationary adjustments. The providers impacted by this inflationary deferral are:

Outpatient Hospitals:

Effective for dates of service April 1, 2009 and after, the percent of charges paid to each hospital shall be reduced by an amount for each hospital that will result in a net aggregate reduction in projected payments of 3%. Such deferred adjustment shall remain in effect until further notice.

Community Pharmacies:

Effective for dates of service April 1, 2009 and after, claims for drug ingredient costs reimbursed based on a percentage of the Average Wholesale Price (AWP) shall be reimbursed at AWP minus 16%. Such deferred adjustment shall remain in effect until further notice. [See Agency Response to Public Comments Below]

Non-Traditional Pharmacies:

Effective for dates of service April 1, 2009 and after, claims for drug ingredient costs reimbursed based on a percentage of the Average Wholesale Price (AWP) shall be reimbursed at AWP minus 18%. Such deferred adjustment shall remain in effect until further notice.

Physicians:

Effective for claims paid on or after April 1, 2009 claims that are based on the Medicare rate shall be reimbursed at 98% of the Medicare rate. Such deferred adjustment shall remain in effect until further notice.

Laboratories:

Effective for claims paid on or after April 1, 2009 claims that are based on the Medicare rate shall be reimbursed at 98% of the Medicare rate. Such deferred adjustment shall remain in effect until further notice.

Dental:

Effective for dates of service April 1, 2009 and after, dental claims reimbursed as a percent of charges shall be reimbursed at 80% of charges. Such deferred adjustment shall remain in effect until further notice.

Ambulatory Surgical Centers:

Effective for dates of service April 1, 2009 and after, ambulatory surgical centers shall be reimbursed at 95% of the Medicare rate. Such deferred adjustment shall remain in effect until further notice.

Dialysis Centers:

Effective for dates of service April 1, 2009 and after, dialysis centers shall be reimbursed at 85% of charges. Such deferred adjustment shall remain in effect until further notice. ***[See Agency Response to Public Comments Below]***

The provisions of this amendment are contingent upon approval of the Centers for Medicare and Medicaid Services (CMS).

Summary of Comments Received with Agency Response

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows.

The proposed reductions must be viewed within the context of the overall economy and the State budget shortfall. The Councils regret the reductions in reimbursement rates but understands the justification based on the State budget.

In a nutshell, the changes are as follows.

- Reimbursement rates for inpatient hospital services, outpatient hospital services based on a fee schedule, private nursing facility services, and private ICF/MRs will be rolled back to December 31, 2008 standards (pp. 1487, 1491, 1499).
- Reimbursement rates for pediatric nursing facility services and prescribed pediatric extended care will be rolled back to March 31, 2009 standards (pp.1482, 1502).
- Reimbursement rates for outpatient hospitals based on a percentage of charges will be reduced by 3% (p. 1487).
- Reimbursement rates for community pharmacy and non-traditional pharmacy drug acquisition costs will be reduced by 2%, i.e., from the average wholesale price (AWP) minus 14% and 16%, to AWP minus 16% and 18% respectively. The dispensing rate of $3.65 is unchanged (p. 1489).
- Reimbursement rates for free standing surgical centers will be reduced from 100% of Medicare rates to a minimum of 95% of Medicare rates (p. 1490).
- Reimbursement rates for physicians and labs will be reduced to 98% of the Medicare rate.
- Reimbursement rates for dental services will be reduced from 85% of charges to 80% of charges (p. 1490).
- Reimbursement rates for dialysis centers are reduced to 85% of charges (p. 1483).

We also understand that the regulation may inadvertently omit intended provisions identified below. The GACEC and the SCPD would like to share the following observations.

First, federal Medicaid law requires the State to offer payments that are sufficient to ensure some minimum level of availability of providers. See, e.g., attached descriptions of Massachusetts and Arizona litigation. The level of reimbursement reductions in the DMMA regulation may not be so deep as to prompt a wholesale exodus of providers from participation in the Medicaid program. However, the State must be mindful that it cannot reduce provider compensation to levels that would result in a severe lack of providers of covered services.

Agency Response: Per Section 1902(a)(30)(A) of the Social Security Act, payment rates must be consistent with efficiency, economy and quality of care. These proposed rate changes reflect our conclusion that a broad-based package of moderate, equitable rate adjustments is a better approach to preserving quality care than reductions in eligibility or benefits. Understanding the potential negative reaction from providers, DMMA conducted outreach efforts with affected provider groups prior to publishing public notice of the rate adjustments. The rate adjustments were also presented and discussed at Medical Care Advisory Committee (MCAC) meetings and a Provider Bulletin was posted on the DMAP website. While none of the provider groups was happy about the adjustments, they did understand the need for the adjustments and have generally been supportive. We appreciate the cooperation of providers and thank them for their continued service to those who rely on Medicaid.

Second, although the summary of the regulation (pp. 1482-1483) outlines changes effected by the amendments to the State Medicaid Plan, the Council could not locate the actual amendments for providers listed

and underlined in the regulation, i.e., physicians, labs, and dialysis centers. Moreover, Council is assuming that the private Intermediate Care Facility for persons with Mental Retardation (ICF/MR) rates may be incorporated in the nursing facility rates and that the pediatric nursing facility rates are contained in a separate document. See p. 1502 [individual rates of care established per child]. DMMA should be encouraged to review the regulation to determine if some intended amendments were inadvertently omitted from the actual regulation.

Agency Response: The Medicaid State Plan describes reimbursement methodologies for Medicaid covered services. In some cases, the reimbursement methodology may be described in more general terms in the State Plan. For example, physicians are paid based on Medicare payment levels. Public notice is required when the actual percentage of Medicare paid is changed but a State Plan Amendment is not needed. The ICF/MR and Pediatric Nursing Facility Methodologies are both part of the Long Term Care Facilities section of the State Plan.

Third, consistent with the June 4 Delaware Health and Social Services (DHSS) press release and June 5 News Journal article, Walgreens has decided to no longer accept Medicaid for prescription drugs given the two percent rate reduction. DHSS indicates that it offered to compromise at one percent but Walgreens rejected that offer. The two percent standard was expected to save the State $1 million. The article suggests that DHSS now intends to adopt a one percent standard rather than the two percent standard reflected in the proposed regulation. Walgreens indicated that it would take a loss in filling each brand name prescription and encouraged DHSS to achieve cost savings by "pushing doctors to prescribe more generic drugs". Alan Levin, the former Happy Harry CEO and current State director of economic development, opined that the DHSS offer was fair.

Agency Response: DMMA adjusted reimbursement for community pharmacies to AWP minus 16% effective April 1, 2009. This change was one component of a comprehensive package of provider rate adjustments. DMMA asserts that the April 1, 2009 rate is sufficient and supported by available data. DMMA also sought guidance from a pharmacy consultant who expressed the opinion that Delaware's pharmacy network is sufficient to provide adequate access even if a chain pharmacy ceased to participate. However, after consideration of public comments received, implementation of the pharmacy and renal dialysis centers rate adjustments, as proposed in the June 1, 2009 issue of the Delaware Register of Regulations at 12 DE Reg. 1481, have been revised, as follows:

1. Community Pharmacies - Effective for dates of service July 1, 2009 and after, claims for drug ingredient costs reimbursed based on a percentage of the Average Wholesale Price (AWP) shall be reimbursed at AWP minus 15%.

2. Renal Dialysis Facility Services - Effective for dates of service on and after July 1, 2009, renal dialysis facilities shall be paid using the lesser of the facilities' usual and customary (U & C) charges or 100% of the Medicare rate.

In compliance with 42 CFR §447.205 and the Administrative Procedures Act, Public Notice was published before the proposed effective date of the change on June 29, 2009 in the two newspapers of widest circulation in the State, the *News Journal* (New Castle County, Kent County, Sussex County) and, the *Delaware State News* (Kent County). These changes will, also, be adopted in a proposed regulation in a future issue of the *Delaware Register of Regulations*.

No changes were made to the text of the proposed state plan pages as a result of these comments.

Findings of Fact:

The Department finds that the proposed changes as set forth in the June 2009 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation regarding the reimbursement methodology for the above-referenced Medicaid services is adopted and shall be final effective August 10, 2009.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #09-27a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF DELAWARE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL CARE

Reimbursement Principle

Effective for discharges on or after July 1, 1994, the Delaware Medicaid Program will reimburse all acute care hospitals at prospective per discharge rates.

The prospective rates are set by accommodation type. Reimbursement rates have been set for two accommodation types: general services and nursery services. For each of these accommodation types, there are three components to the payment: operating payment per discharge, capital payment per discharge and medical education payment per discharge.

Rate Setting Method – Operating Payment

The base year is the Delaware hospitals' 1992 fiscal year. The operating payment per discharge for the base year was calculated by applying a cost-to-charge ratio to allowed charges from the Medicaid claims data. This allowed cost value was then divided by the total charges to obtain the operating payment per discharge.

The cost-to-charge ratio was identified from FY92 hospital cost reports; the categories of cost included in the cost-to-charge ratio are those related to routine services (including hospital-based physicians' costs and malpractice costs) and ancillary services.

The allowed charge data was taken from the FY92 Medicaid claims data for Delaware hospitals. Medicaid allowable hospital-specific charges associated with inpatient revenue codes appropriate to the accommodation type were identified. The hospital-specific cost-to-charge ratio was applied to the allowed charges to obtain hospital-specific allowed costs for the accommodation type.

~~Effective July 1, 2006, the fiscal year/period for the reimbursement of Medicaid hospital services will be based on a fifteen month period. A rate adjustment will be made on July 1, 2006 and for every fifteen month period thereafter.~~

The total hospital-specific allowed costs for the accommodation type were then divided by the total number of discharges on the claims date for the accommodation type to obtain the hospital-specific operating payment per discharge in the base year.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL CARE (CONTINUED)

Rate Setting Method – Capital Payment Per Discharge

For the capital payment per discharge, a hospital-specific prospective rate was calculated for each accommodation type based on a blended percentage of total costs for each hospital represented by capital. A hospital-specific capital percentage was calculated by dividing allowable capital costs for the hospital by total allowable costs for the facility as reported on each facility's FY92 cost report. A Statewide capital percentage was calculated by dividing total allowable capital costs for all Delaware hospitals by total allowable costs for all hospitals as reported on the cost report. The blended percentage is calculated by taking 75 percent of the hospital-specific capital percentage and 25 percent of the Statewide capital percentage. This blended percentage is then applied to the hospital opening rate per discharge to obtain the hospital capital per discharge rate.

Rate Setting Method – Medical Education Payment Per Discharge

For the medical education payment per discharge, a hospital-specific prospective rate was calculated for each accommodation type based on the percentage of total costs for each hospital represented by medical education costs. A hospital-specific medical education percentage was calculated by dividing total medical education allowable costs for the hospital by allowable total costs for the facility as reported on each facility's FY92 cost report. This hospital-specific percentage is then applied to the hospital operating rate per discharge to obtain the hospital medical education per discharge rate.

Rate Setting Method – Development of Implementation Year Operating Rates, Updates and Rebasing

The new inpatient rates will be implemented effective State FY95. The hospital-specific operating payments per discharge have been established for the implementation year by inflating the hospital-specific base year costs using the TEFRA target rate of increase limits published by HCFA. Base year costs were inflated from the midpoint of each hospital's base year to the midpoint in State fiscal year 1995.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL CARE (Continued)

Rate Setting Methods - Development of Implementation Year Operating Rates, Updates and Rebasing (Continued)

The implementation year rates will be updated in FY96 using published TEFRA inflation indices. Rates will be rebased using fiscal year 1994 claims and cost report data for implementation in State FY97.

Effective for admission dates on or after April 1, 2009, payment rates for inpatient hospital care will be adjusted to the rates that were in effect on December 31, 2008. Future rate adjustments will be suspended until further notice.

Other Related Inpatient Reimbursement Policies

Outliers - High cost outliers will be identified when the cost of the discharge exceeds the threshold of three times the hospital operating rate per discharge. Outlier cases will be reimbursed at the discharge rate plus 79 percent of the difference between the outlier threshold and the total cost of the case. Costs of the case will be determined by applying the hospital-specific cost to charge ratio to the allowed charges reported on the claim for discharge.

Effective January 1, 2006, any provider with a high cost client case (outlier) will receive an interim payment; that is, a payment prior to the discharge of that patient when the charge amount reaches the designated level. An interim payment will be made for that inpatient stay when the client's charges have reached twenty-five (25) times the general discharge rate of that facility, or when the client's stay is greater than sixty (60) days. Additional interim payments will be made when either of the outlier conditions for an interim payment is met again. The interim payment amount is based on the current reimbursement methodology used to pay outliers. Upon the discharge of the client, the facility will receive the balance of the payment that would have been paid if the case were paid in full at the time of discharge.

Transplants - Transplant cases will be treated as outliers and, when appropriate, will be subject to the outlier payment policy. Organ acquisition costs will not reimbursed separately, but will be included in the per discharge rate.

Transfers/readmissions - There will be no distinct payment policy for transfers/ readmissions between hospitals. These cases will be paid on a discharge basis. The PRO will conduct a periodic review to monitor these types of cases and determine that discharges are appropriate.

Split bills - For in-State cases and Out-of-State hospitals receiving per diem payment that span FY94 and FY95, the cost associated with the days in FY94 will be reimbursed using the current methodology. The full per-discharge rate will be paid for the days of care in FY95. Out of State hospitals who already use DRGs or a per discharge methodology will be paid the per discharge rate for all discharges on or after July 1, 1994.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL CARE (Continued)

Out-of-State Hospitals

The operating, capital and medical education rates for acute care hospitals located outside of Delaware will be paid at the lowest Delaware rate for the hospital category to which they are assigned. Three categories of Delaware hospitals have been identified: urban, rural and major teaching. Out of state teaching hospitals are defined as those facilities which are members of the Council of Teaching Hospitals. Out of state urban hospitals are defined as non-teaching hospitals located in a metropolitan statistical area (MSA) as identified by the U.S. Bureau of Census. Out of state rural hospitals are defined as non-teaching hospitals located outside a metropolitan statistical area "MSA" as defined by the U.S. Bureau of Census. Out-of-State specialty/rehab hospitals will be paid at the Medicaid rate established by the State in which they are located.

Disproportionate Share Hospital Payments

In accordance with the provisions of Section 1923(b)(1)(A)(B) of the Social Security Act, the Delaware Medicaid Program will determine whether a hospital qualifies as "serving a disproportionate share of the poor".

Medicaid defines uncompensated care as the cost of services to Medicaid patients, less the amount paid by the State under the non-disproportionate share hospital payment provisions of the State Plan. The cost of services to uninsured patients (those who have no health insurance or source of third party payments) less the amount of payments made by these patients is included in the definition of uncompensated care. Any hospital meeting the definition of a disproportionate share hospital will receive payments in accordance with Section 1923 (c)(3). Hospitals meeting the standard are entitled to receive payments of ninety percent (90%) of its uncompensated care amount.

Medicaid requires that the 1923(d)(3) provision of the Act be met, which states that any disproportionate share hospital have a Medicaid utilization rate of a least one percent (1%).

With the exceptions noted in 1923(d)(2)(A), Medicaid also requires that the 1923(d) provision of the Act be met, which states that any disproportionate share hospital have at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan.

Medicaid requires that the payment adjustments received by all disproportionate share hospitals not exceed, in the aggregate, the established limits each Federal fiscal year as expressed in Section 1923(f) of the Act as published annually in the HCFA Federal Register. Medicaid also requires that the payment adjustments made to individual hospitals not exceed one hundred percent (100%) of their established limits for the State fiscal year as expressed in Section 1923(g) of the Act.

Hospitals With New Programs/Services

For hospitals who begin a new medical education program for which there is no historical cost or claims data, the medical education payment will be paid at the average percentage for the Delaware teaching hospital category to which they are assigned. There are two categories of Delaware hospitals with regard to teaching: major teaching hospitals are defined as those facilities which are members of the Council of Teaching Hospitals. Minor teaching hospitals are all other hospitals in the state with a medical education program recognized by the Delaware Medicaid program.

Hospitals with other categories of new services can appeal their reimbursement rates using the appeals process.

A.I. duPONT INSTITUTE OF THE NEMOURS FOUNDATION

Reimbursement Principle

Effective for discharges on or after January 1, 1995 the Medicaid Program will reimburse A.I. duPont Institute on the basis of prospective per discharge rates. Costs determined for A.I. duPont are hospital-specific but otherwise determined using the same methodology as the other acute care hospitals.

A.I. duPont's per discharge rate will be discounted by the Institute through agreement with the Medicaid agency, not to exceed the rate established for comparable care in Delaware's other large teaching hospital. Rebasing and indexing of A.I. duPont's costs will be done on the same schedule as the other in-State acute care hospitals but specific to their fiscal year.

DMMA FINAL ORDER REGULATION #09-27b

REVISIONS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF DELAWARE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OUTPATIENT HOSPITAL CARE

Payment Methodology for Rate Periods Beginning January 1, 2009

A. Effective for dates of service on or after April 1, 2009, outpatient hospital care rates based on a hospital specific fee schedule will be adjusted to the rates that were in effect on December 31, 2008.
B. Effective for dates of service on or after April 1, 2009, outpatient hospital care payments based on a percent of charges will be adjusted by an amount for each hospital that will result in a net aggregate reduction in projected payments of 3%.
C. All future outpatient hospital care rate adjustments will be suspended until further notice.

Reimbursement Principle

Effective with the start of the provider's fiscal year on or after July 1, 1994, the Delaware Medicaid program will reimburse A.I. duPont/acute care hospitals for outpatient services using the following payment methods:

- Prospective rate for visit services provided in the emergency room, outpatient clinic and outpatient delivery/labor room
- Submitted charges converted to costs for stand alone services identified by revenue code
- Fee schedule allowances for laboratory services

The base year for the outpatient payment methodology is FY92. Medicaid claims data and hospital cost reports from FY92 served as the sources of data for calculation of the outpatient payment amounts.

~~The established rates and methodology for hospital outpatient reimbursement shall be reviewed annually by the Delaware Medicaid program and adjusted, as necessary.~~

Rate Setting Method - Visit Services

Visit services will be paid using a prospective flat rate. There are four types of visit services:

- Emergency
- Non-emergency
- Clinic
- Delivery/labor room

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OUTPATIENT HOSPITAL CARE (Continued)

Rate Setting Method - Visit Services (Continued)

Each type of visit service is defined by a set of outpatient revenue codes. In addition, emergency visit services must be associated with an ICD-9 diagnosis code defined as a "true emergency" by the Delaware Medicaid program.

The flat rate for each visit service is based on a blend of the following:

- 75 percent of the hospital-specific mean billed allowed cost for FY95 for the revenue codes associated with the visit category
- 25 percent of the statewide mean billed allowed cost for FY95 for the revenue codes associated with the visit category

The hospital-specific mean billed cost was calculated using allowed charges from the Medicaid base year claims data associated with the revenue codes for each visit category. Allowed charges were derived from the claims data on a per visit basis for each revenue type using FY92 claims data. The allowed charges per visit included allowed charges for a standard set of revenue codes that identified drugs and supplies associated with the visit service.

The allowed charges per visit were then converted to cost using a hospital-specific cost to charge ratio for ancillary services from the hospitals' FY92 cost reports. A hospital-specific mean billed allowed cost was calculated for each type of visit by taking the mean of all the per visit allowed costs for the hospital converted from the claims data. The Statewide billed cost was calculated by taking the mean of all the per visit allowed costs across all in-state hospitals, except A.I. duPont.

Both the hospital-specific mean and statewide mean costs were inflated to the midpoint of the base year to the midpoint to the implementation year (FY95) using the DRI Hospital Marketbasket.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OUTPATIENT HOSPITAL CARE (Continued)

Rate Setting Method - Stand-Alone Services

Stand-alone services encompass all other services provided in the outpatient setting that cannot be grouped into a visit category. A stand-alone service will be identified one of two ways:

- By revenue code
- By CPT code

Stand-alone services identified by revenue code will be paid using a hospital-specific cost-to-charge ratio for the revenue department. Each revenue code is assigned to a revenue department, based on the revenue departments listed in the hospital cost report. The cost to charge ratio for the revenue department was identified from the hospitals' FY92 cost reports and will be applied to the charges reported on the claim to obtain the payment amount for the revenue code.

Stand-alone services identified by HCPCS code will be paid using a fee schedule. Effective July 1, 1994, the only services to be identified using HCPCS codes are laboratory services included in the Medicare clinical laboratory fee schedule. These services will be reimbursed using the same methodology and fee schedule that is currently being used.

Effective for services provided on or after November 1, 1994, radiology services, identified by HCPCS code, will be reimbursed using a fee schedule.

DMMA FINAL ORDER REGULATION #09-27c
REVISIONS:

State/Territory DELAWARE

Reimbursement for pharmaceuticals:

Overview

The Delaware Medical Assistance (DMAP) program will reimburse pharmaceuticals using the lower of

- The usual and customary charge to the general public for the product,
- The Estimated Acquisition Cost (EAC) which is defined for both brand name and generic drugs as follows:
  - For Traditional Pharmacies: AWP minus ~~14%~~ 16% plus dispensing fee per prescription, effective for dates of service on or after April 1, 2009
  - For Non-Traditional Pharmacies: AWP minus ~~16%~~ 18% plus dispensing fee per prescription, effective for dates of service on or after April 1, 2009
- A State-specific maximum allowable cost (DMAC) and, in some cases, the Federally defined Federal Upper Limit (FUL) prices plus a dispensing fee.

Entities that qualify for special purchasing under Section 602 of the Veterans Health Care Act of 1992, Public Health Service covered entities, selected disproportionate share hospitals and entities exempt from the Robinson-Patman Price Discrimination Act of 1936 must charge the DMAP no more than an estimated acquisition cost (EAC) plus a professional dispensing fee. The EAC must be supported by invoice and payment documentation.

Dispensing Fee:

The dispensing fee rate is $3.65. There is one dispensing fee per 30-day period unless the class of drugs is routinely prescribed for a limited number of days.

Definitions:

Delaware Maximum Allowable Cost (DMAC) - a maximum price set for reimbursement:

- for generics available from three (3) or more approved sources, or
- when a single source product has Average Selling Prices provided by the manufacturer that indicates the AWP is exaggerated, or
- if a single provider agrees to a special price.

Any willing provider can dispense the product.

<continued on page 14a>

Federal Upper Limit (FUL) - The FUL is a federally defined price and constitutes the upper limit of reimbursement where a DMAC limit does not exist.

Non-Traditional Pharmacy - long term care and specialty pharmacies.

Traditional Pharmacy - retail independent and retail chain pharmacies.

Reimbursement Policy:

- Medicaid reimbursement is limited to only those drugs supplied from manufacturers that have a signed national agreement or an approved existing agreement under Section 1927(a) of the Social Security Act. Restrictions in drug coverage are listed on Page 5 Addendum of Attachment 3.1-A of this Plan.

Exceptions:

- Exceptions to the reimbursement of FUL and DMAC can be made if a physician certifies in their own handwriting that a specific brand is medically necessary. The medical necessity must be documented on a FDA Med-Watch form based on the client experiencing an adverse reaction.
- Other exceptions will be made if documentation provided demonstrates that the product can only be obtained a higher rate.

DMMA FINAL ORDER REGULATION #09-27d
REVISIONS:

State: DELAWARE

REIMBURSEMENT FOR FREE STANDING SURGICAL CENTER / AMBULATORY SURGICAL CENTER SERVICES

Delaware Medicaid uses the reimbursement methodology and formulae of the Medicare program, as described in Section 5243 of the Medicare Carriers Manual, in determining per diem rates for payment of Free Standing Surgical Centers (FSSCs) / Ambulatory Surgical Centers (ACS). Delaware Medicaid may reimburse at a percent of the Medicare calculated rate described above, up to 100% but no lower than 95%.

DMMA FINAL ORDER REGULATION #09-27e
REVISIONS:

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services are reimbursed as follows:

1. Screening services - fee-for-service.
2. Treatment services - fee-for-service.
3. Dental Treatment - reimburse ~~85%~~ 80% of billed charges for routine dental services for dates of service on or after April 1, 2009.

4. Specialized Dental Services - reimburse (a) a percentage of charges for non-orthodontic related services and (b) a flat fee-for-service for orthodontic related services.

a. Percentage of Charges for non-orthodontic services – Effective for dates of service on or after April 1, 2009, ~~The~~ the State pays ~~85%~~ 80% of billed charges for medically necessary non-orthodontic dental care, determined by: 1) the consideration that 65-70% of the usual & customary rate is nationally known to account for the dental provider's actual costs; and, 2) an allowance of an additional mark-up to permit a reasonable and fair profit and as incentive for providers to participate in the Medicaid Program in order to create adequate access to dental care.

b. Flat Fee-for-Service for orthodontic services – The State identifies three primary orthodontic related services that encompass orthodontic reimbursement: 1) Pre-orthodontic treatment visit; 2) Comprehensive orthodontic treatment of the adolescent dentition; and, 3) Periodic orthodontic treatment visit. Rates for each orthodontic service are determined by adopting the 75th percentile of orthodontic rates paid by the Division of Public Health Special Dental Program, which, compare favorably to commercial coverage and encourage provider participation and adequate access to orthodontic care. Care provided outside of these three services will be reimbursed at a percentage of charges. Medicaid reimbursement for these three orthodontic services will be the lower of the submitted charges or the established Medicaid rate.

DMMA FINAL ORDER REGULATION #09-27f
REVISIONS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES
STATE PLAN AMENDMENT 4.19-D

Payment Methodology for Rate Periods Beginning January 1, 2009

A. Notwithstanding any other provision of this section, the following adjustments will apply to reimbursement rates for all long term care facilities, except for state owned and operated facilities.
B. Effective for dates of service on or after April 1, 2009, per diem rates for long term care facilities will be adjusted to the rates that were in effect on December 31, 2008.
C. Future rate adjustments will be suspended until further notice.

I. General Provisions

A. Purpose

This plan establishes a reimbursement system for long-term care facilities that complies with federal requirements, including but not limited to:

- Requirements of the Omnibus Reconciliation Act of 1981 that nursing facility provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility.
- The requirement that Medicaid payments in the aggregate do not exceed what would have been paid by Medicare based on allowable cost principles.
- Limitations on the revaluation of assets subsequent to a change of ownership since July 18, 1984.
- Requirements of the Omnibus Reconciliation Act of 1987 to establish one level of nursing care, i.e., Nursing Facility Care, to eliminate the designation of Skilled and Intermediate Care, and to provide sufficient staff to meet these requirements.
- The requirement to employ only nurse aides who have successfully completed a training and competency evaluation program or a competency evaluation program.

B. Reimbursement Principles

1. Providers of nursing facility care shall be reimbursed prospectively determined per diem rates based on a patient based classification system. Providers of ICF-MR and ICF-IMD services shall be reimbursed prospectively determined per diem rates.

2. The Delaware Medicaid Program shall reimburse qualified providers of long-term care based on the individual Medicaid recipient's days of care multiplied by the applicable per diem rate for that patient's classification less any payments made by recipients or third parties.

II. Rate Determination for Nursing Facilities

A. Basis for Reimbursement

Per Diem reimbursement for nursing facility services shall be composed of five prospectively determined rate components that reimburse providers for primary patient care, secondary patient care, support services, administration, and capital costs.

The primary patient care component of the per diem rate is based on the nursing care costs related specifically to each patient's classification. In addition to assignment to case mix classifications, patients may qualify for supplementary primary care reimbursement based on their characteristics and special service needs. Primary care component reimbursement for each basic patient classification will be the same for each facility within a group. For the purpose of establishing rates, nursing facilities shall be divided into groups of like facilities for which a schedule of primary rates, including rate additions, is established for each group:

Peer Group A	Private facilities in New Castle County and public facilities located in New Castle County at the discretion of the Medicaid Director
Peer Group B	Private facilities in Kent and Sussex Counties and public facilities located in Kent and Sussex Counties at the discretion of the Medicaid Director
Peer Group C	Public facilities operated by the State of Delaware

Payment for the secondary, support, administrative, and capital costs comprise the base rate, and is unique to each facility. Provider costs are reported annually to Medicaid and are used to establish rate ceilings for the secondary, support, and administrative cost centers in each provider group.

The sections that follow provide specific details on rate computation for each of the five rate components.

B. Rate Components

Payment for services based on the sum of five rate components. The rate components are defined as:

- **Primary Patient Care.** This cost center encompasses all costs that are involved in the provision of basic nursing care for nursing home patients and is inclusive of nursing staff salaries, fringe benefits, and training costs. All nurses' salaries, fringe benefits, and training for staff with duties that count towards the minimum staff requirements will be included in this cost center.

- **Secondary Patient Care.** This cost center encompasses other patient care costs that directly affect patient health status and quality of care and is inclusive of clinical consultants, social services, raw food, medical supplies, and non prescription drugs, dietitian services, dental services (in public facilities only), and activities personnel.

- **Support Services.** This cost center includes costs for departments that provide supportive services other than medical care and is inclusive of dietary, operation and maintenance of the facility, housekeeping, laundry and linen, and patient recreation.
- **Administrative.** This category includes costs that are not patient related and is inclusive of owner/ administrator salary, medical and nursing director salary (excluding such time spent in direct patient care), administrative salaries, medical records, working capital, benefits associated with administrative personnel, home office expenses, management of resident personal funds, and monitoring and resolving patient's rights issues.
- **Capital.** This category includes costs related to the purchase and lease of property, plant and equipment and is inclusive of lease costs, mortgage interest, property taxes and depreciation.

C. Excluded Services

Those services to residents of private long term care facilities that are ordinarily billed directly by practitioners will continue to be billed separately and are not covered by the rate component categories. This includes prescription drugs, Medicare Part B covered services, physician services, hospitalization and dental services, laboratory, radiology, and certain ancillary therapies.

For public facilities, laboratory, radiology, prescription drugs, physician services, dental services, and ancillary therapies may be included in the per diem.

Costs of training and certification of nurse aides are billed separately by the facilities as they are incurred, and reimbursed directly by Medicaid.

D. Primary Payment Component Computations

The primary patient care rate component is based on a patient index system in which all nursing home patients are classified into patient classes. The lowest resource intensive clients are placed in the lowest class.

The Department will assign classes to nursing home patients. Initial classification of patients occurs through the State's pre-admission screening program. These initial classifications will be reviewed by Department nurses within 31 to 45 days after assignment. Patient classification will then be reviewed at least twice a year. Facilities will receive notices from the Department concerning class changes and relevant effective dates.

1. In order to establish the patient classification for reimbursement, patients are evaluated and scored by Medicaid review nurses according to the specific amount of staff assistance needed in Activity of Daily Living (ADL) dependency areas. These include Eating, Mobility, Transfer, and Toileting. Potential scores are as follows:

0 - Independent

1 - Supervision (includes verbal cueing and occasional staff standby)

2 - Moderate assistance (requires staff standby/physical presence)

3 - Maximum Assistance

Patients receiving moderate or maximum assistance will be considered "dependent" in that ADL area. Patients receiving supervision will not be considered dependent. Reimbursement is determined by assigning the patient to a patient classification based on their ADL scores and the provision of any Clinical Care Items.

Each patient classification is related to specific nursing time factors. These time factors are multiplied by the 75^{th} percentile nurse wage in each provider group to determine the per diem rate for each classification.

2. Patients receiving an active rehabilitative/preventive program as defined and approved by the Department shall be reimbursed an additional 20% of the primary care rate component.

To be considered for the added reimbursement allowed under this provision, a facility must develop and prepare an individual rehabilitative/preventive care plan. This plan of care must contain rehabilitative/ preventive care programs as described

in a Department approved list of programs. The services must seek to address specific activity of daily living and other functional problems of the patient. The care plan must also indicate specific patient goals, and must have a physician's approval.

The Department will evaluate new facility-developed rehabilitative/preventive care plans during its patient classification reviews of nursing homes.

Interim provisional approval of plans can be provided by Department review nurses. When reviewed, the Department will examine facility documentation on the provision of rehabilitative/preventive services to patients with previously approved care plans as well as progress towards patient goals.

3. Patients exhibiting disruptive psycho social behaviors on a frequent basis as defined and classified by the Department shall receive an additional 10 percent of the primary care rate component for the appropriate classification.

The specific psychosocial behaviors that will be considered for added reimbursement under this provision are those that necessitate additional nursing staff intervention in the provision of personal and nursing care. Such behaviors include: verbal and physically disruptive actions, inappropriate social behavior, non-territorial wandering, and any other similar patient problems as designated by the Department.

Facilities must have complete documentation on frequency of such behaviors in a patient's chart for the Department to consider the facility for added reimbursement under this provision. This documentation will be evaluated during patient classification reviews of a nursing home.

4. Patient class rates are determined based on the time required to care for–patients in each classification, and nursing wage, fringe benefit, and training costs tabulated separately for each facility peer group.

Primary rates are established by the following methodology:

- Annual wage surveys and cost reports required of each provider are used to determine 75th percentile hourly nursing wages for Peer Groups A and B. For Peer Group C, wage surveys and cost reports are combined and treated as one facility prior to determining the 75th percentile.

The cost report used in the calculations will represent the fiscal year ending June 30th of the previous reimbursement year. The Delaware reimbursement year, for purposes of rate setting, is from January 1 through December 31 for Peer Groups A and B, and October 1 through September 30 for Peer Group C.

This is calculated by first dividing total pay by total hours for each nursing classification (RN, LPN, Aide) in each facility, then arraying them to determine the 75th percentile within each provider group. Based on cost data from each provider group, hourly wage rates are adjusted to include hourly training and fringe benefit costs within each provider group.

- In each of the provider peer groups the rates are established in the same manner.

  The primary component of the Medicaid nursing home rate is determined by multiplying the 75th percentile hourly nursing wage for RNs, LPNs, and Aides by standard nursing time factors for each of the base levels of patient acuity.
- Providers will be reimbursed for agency nurse costs if their use of agency nurses does not exceed the allowable agency nurse cap determined each year by the Delaware Medicaid staff. Any nursing cost incurred in excess of the allowable cap will not be included in the nursing cost calculation.
- Within each of the patient classes, Medicaid provides "Incentive add-ons" to encourage rehabilitative and preventive programs. Rehabilitative and preventive services shall be reimbursed an additional 20% of the primary care rate component. Incentive payments discourage the deterioration of patients into higher classifications.

- Patients exhibiting disruptive psychosocial behaviors on a frequent basis as defined by the Department and are receiving an active psychosocial/preventive program as defined and approved by the Department shall be reimbursed an additional 10% of the primary care rate component.

- Patients receiving an active rehabilitative/preventive program and a psychosocial/preventive program as defined by the Department shall be reimbursed an additional 20% of the primary care rate component plus an additional 10% of the rehabilitative/preventive rate (32% of the primary care rate component).

E. Non-primary Rate Component Computations

Facility rates for the four non-primary components of secondary, support, administrative, and capital are computed from annual provider cost report data on reimbursable costs. Reimbursable costs are defined to be those that are allowable based on Medicare principles, according to HIM 15. Costs applicable to services, facilities, and supplies furnished to a provider by commonly owned, controlled or related organizations shall not exceed the lower cost of comparable services purchased elsewhere.

The cost report used in the calculations will represent the fiscal year ending June 30th of the previous reimbursement year. The Delaware reimbursement year, for purposes of rate setting is from January 1 through December 31 for Peer Groups A and B and October 1 through September 30 for Peer Group C.

- Individual allowable cost items from cost reports for each facility comprising the base rate component are summed and divided by patient days. For established facilities, the patient day amount used in this computation equal actual patient days or estimated days based on a 90 percent occupancy of Medicaid certified beds, whichever is greater. The day amount for new facilities[1] equals actual patient days for the period of operation, or estimated days based on a 75 percent occupancy of Medicaid certified beds, whichever is greater. This applies to cost centers comprising the basic rate.

The discussion that follows explains rate computation for the secondary, support, administrative and capital payment centers.

1. Secondary patient care rates are reimbursed according to the cost of care determined prospectively up to a calculated ceiling (115 percent of median per diem costs). Using the same facility peer grouping that was determined for the calculation of the primary care payment component, the following steps are required:

- Facilities are grouped into three peer groups – private facilities in New Castle County, private facilities in Kent and Sussex Counties, and public facilities.

- Individual allowable cost items from cost reports for each facility comprising the secondary care component are summed and divided by patient days. For established facilities, the patient day amount used in this computation equals actual patient days or estimated days based on a 90 percent occupancy of Medicaid certified beds, whichever is greater. The day amount for new facilities[1] equals actual patient days for the period of operation, or estimated days based on a 75 percent occupancy of Medicaid certified beds, whichever is greater.
- The median per diem cost is determined for each category of facility and inflated by 15 percent. The secondary care per diem assigned to a facility is the actual allowable cost up to a maximum of 115 percent of the median.

2. Support service component rates are determined in a manner that parallels the secondary component rate calculation process. However, the ceiling is set at 110 percent of median support costs per day for the appropriate category of facility. In addition, facilities, which maintain costs below the cap, are entitled to an incentive payment 25 percent of the difference between the facility's actual per day cost and the applicable cap, up to a maximum incentive of 5 percent of the cap amount.

* "New facility" is defined as: (1) New construction built to provide a new service of either intermediate or skilled nursing care for which the existing facility has never before been certified, or (2) construction of an entirely new facility totally and administratively independent of an existing facility.

3. Administrative component rates are determined in a manner parallel to the secondary component. However, the ceiling is set at 105 percent of median costs per day. A facility is entitled to an incentive payment of 50 percent of the difference between its actual costs and the cap. The incentive payment is limited to 10 percent of the ceiling amount.

4. Capital component rates are determined prospectively and are subject to a rate floor and rate ceiling. The dollar amounts representing the 20th percentile of actual per diem capital cost (floor) and the 80th percentile of actual per diem capital cost (ceiling) are calculated. If the facility's costs are greater than or equal to the floor, and less than or equal to the ceiling, the facility's prospective rate is equal to its actual cost. If the facility's costs are below the floor, the prospective rate is equal to the lower of the floor or actual cost plus twenty-five percent of actual cost. If the facility's costs are greater than the ceiling, the prospective rate is equal to the higher of the ceiling or ninety-five percent of actual cost. Costs associated with revaluation of assets of a facility will not be recognized.

The capital component is also subject to the occupancy standards as set forth in section II.E. of State Plan Amendment 4.19-D. The capital component rate is calculated on a statewide basis.

5. Where services are currently contracted by the nursing facility to a practitioner, additional services may be billed directly. These services are not covered by the rate component categories for private facilities, but may be included in the rate for public facilities. These services include therapies, physician services, dental services and prescription drugs.

F. Computation of Total Rate from Components

A facility's secondary, support, administrative, and capital payments will be summed and called its basic rate. The total rate for a patient is then determined by adding the primary rate for which a patient qualifies to the facility's basic rate component. The basic payment amount will not vary across patients in a nursing home. However, the primary payment will depend on a patient's class and qualification for added rehabilitative/preventive and/or psychosocial reimbursement.

G. OBRA '87 Additional Costs

1. Nurse Aide Training and Certification

Providers of long-term care services will be reimbursed directly for the reasonable costs of training, competency testing and certification of nurse aides in compliance with the requirements of OBRA '87. The training and competency testing must be in a program approved by the Delaware Department of Health and Social Services, Division of Public Health. A "Statement of Reimbursement Cost of Nurse Aide Training" is submitted to the state by each facility quarterly.

Costs reported on the Statement of Reimbursement Cost are reimbursed directly and claimed by the State as administrative costs. They include:

- Costs incurred in testing and certifying currently employed nurse aides, i.e., testing fees, tuition, books, and training materials.
- Costs of providing State approved training or refresher training in preparation for the competency evaluation testing to employed nurse aides who have not yet received certification.

- Salaries of in-service instructors to conduct State approved training programs for the portion of their time involved with training, or fees charged by providers of a State approved training program.
- Costs of transporting nurse aides from the nursing facility to a testing or training site.

The following costs of nurse aide training are considered operational, and will be reported annually on the Medicaid cost report. These costs will be reimbursed through the Primary cost component of the per diem rate.

- Salaries of nurse aides while in training or competency evaluation.
- Costs of additional staff to replace nurse aides participating in training or competency evaluation.
- Continuing education of nurse aides following certification.

2. Additional Nurse Staff Requirements

Additional nurse staff required by a nursing facility to comply with the requirements of OBRA '87 will be reimbursed under the provisions of the Delaware Medicaid Patient Index Reimbursement System (PIRS). This system makes no distinction between levels of care for reimbursement. Nursing costs are derived from average hourly wage, benefit, and training cost data provided on the Nursing Wage Survey submitted by each facility. Prospective rates for each patient acuity classification are calculated by these costs by the minimum nursing time factors. Although representative of actual costs incurred, these prospectively determined rates are independent of the number employed or the number of staff vacancies at any given time.

3. Additional Non-Nursing Requirements

The Delaware Medicaid reimbursement system will recognize the incremental costs of additional staff and services incurred by nursing facilities to comply with the mandates of OBRA ’87. Prospective rate calculations will be adjusted to account for costs incurred on or after October 1, 1990.

Where services are currently contracted by the nursing facility to a practitioner, additional services may be billed directly. These services are not covered by the rate component categories (for private facilities, but may be included in the rate for public facilities.) These services include therapies, physician services, dental services, and prescription drugs.

A supplemental schedule to the Statement of Reimbursement Costs (Medicaid Cost Report) will be submitted by each facility to demonstrate projected staff and service costs required to comply with OBRA'87. For the rate year beginning October 1, 1990, facilities may project full year costs onto prior year reported actual costs to be included in the rate calculation.

The supplemental schedule will be used to project costs incurred for programs effective October 1, 1990 into the prospective reimbursement rates. Where nursing care facilities indicate new and anticipated staff positions, those costs will be included with the actual SFY '90 costs when calculating the reimbursement rates effective October 1, 1990.

Additional staff requirements include dietitian, medical director, medical records, activities personnel, and social worker.

H. Hold Harmless Provision

For the first year under the patient index reimbursement system the Department will have in effect a hold-harmless provision. The purpose of the provision is to give facilities an opportunity to adjust their operations to the

new system. Under this provision, no facility will be paid less by Medicaid under the patient index system than it would have been paid had Federal Fiscal Year 1988 rates, adjusted by an inflation factor, been retained.

For the period October 1, 1990 to September 30, 1991, the Department will have in effect a hold-harmless provision with respect to capital reimbursement rates. The purpose of this provision is to give facilities an opportunity to adjust their operations to the new system. Under this provision, facilities will be paid the greater of the rate under the prospective capital rate methodology or the rate based on reimbursable costs. Beginning October 1, 1991, all facilities will be subject to the prospective capital rate methodology described in Section II, E.4.

I. Annual Rate Recalculation

1. Primary Payment Component

Rates for the primary patient care component will be rebased annually. Two sources of provider-supplied data will be used in this rate rebasing:

- An annual nursing wage and salary survey that the Department will conduct of all Medicaid-participating nursing facilities in Delaware.
- Nursing home cost report data on nurses' fringe benefits and training costs.

For Peer Groups A and B, the 75th percentile wages will be redetermined annually from the wage and salary survey, and the standard nurse time factors will be applied for each patient classification. The cost report and wage and salary survey will be for the previous year ending June 30. For Peer Group C, wage surveys and cost reports are combined and treated as one facility prior to determining the 75th percentile.

2. Non-Primary Payment Components

The payment caps for the secondary, support, and administrative components will be rebased every fourth year using the computation methods specified in Section E above. For the interim periods between rebasing, the payment caps will be inflated annually based on reasonable inflation estimates as published by the Department. Facility-specific payment rates for these cost centers shall then be calculated using these inflated caps and cost report data from the most recently available cost reporting period.

The capital floor and ceiling will be rebased annually.

3. Inflation Adjustment

Per Diem caps for primary, secondary, support and administrative cost centers will be adjusted each year by inflation indices. The inflation indices will be obtained from a recognized source and based on an appropriate index for the primary cost center and the following cost centers: secondary, support and administrative.

The inflation factors are applied to the actual nursing wage rates to compensate for the annual inflation in nursing costs. This adjustment is made before the nurse training and benefits are added and the wages are multiplied by the standard nurse time factors.

Examples of inflation indices that may be used includes but is not limited to:

1. Department of Economics, University of Delaware Health Care Index (or other similar university research centers' index).
2. U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index.
3. CMS Prospective Payment System-Skilled Nursing Facility Input Price Index.
4. CMS Excluded Hospital 2002 Input Price Index.

5. CMS Excluded Hospital with Capital Input Price Index.
6. CMS Rehabilitation, Psychiatric, and Long Term Care Hospital with Capital Input Price Index.

Cost center caps are used to set an upper limit on the amount a provider will be reimbursed for the costs in the secondary, support, and administrative cost centers. Initially, these caps are computed by determining the median value of the provider's actual daily costs, then adjusting upwardly according to the particular cost center. The Secondary cost center cap is 115% of the provider group median, and Administrative costs are capped at 105% of the median. Delaware Medicaid will recalculate non-primary cost center caps every fourth year. The next rebase will be for rates effective January 1, 2008 for Peer Groups A and B and October 1, 2007 for Peer Group C. In interim rate years, these cost center caps will not be recomputed. Instead, cost center caps will be adjusted by inflation factors. The inflation index provided by a recognized source will be applied to the current cap in each cost center in each provider group to establish the new cap. The actual reported costs will be compared to the cap. Facilities with costs above the cap will receive the amount of the cap.

J. Medicare Aggregate Upper Limitations

The State of Delaware assures CMS that in no case shall aggregate payments made under this plan, inclusive of DEFRA capital limitations, exceed the amount that would have been paid under Medicare principles of reimbursement. As a result of a change of ownership, on or after July 18, 1984, the State will not increase payments to providers for depreciation, interest on capital and return on equity, in the aggregate, more than the amount that would be recognized under section 1861(v)(1)(0) of the Social Security Act. Average projected rates of payment shall be tested against such limitations. In the event that average payment rates exceed such limitations, rates shall be reduced for those facilities exceeding Medicare principles as applied to all nursing facilities.

III. Rate Determination ICF/MR and ICF/IMD Facilities

Delaware will recalculate the prospective per diem rates for ICF/MRs and ICF/IMDs annually for the reimbursement year, January 1 through December 31 for Peer Groups A and B and October 1 through September 30 for Peer Group C. Within Peer Groups A, B, and C defined in section II.A., there are additional classifications of facilities that affect reimbursement. They are:

1. Public ICF/MR facilities of 8 beds or less.
2. Public ICF/MR facilities of greater than 8 beds.
3. Private ICF/MR facilities of 60 beds or less.
4. Public ICF/IMD facilities.

These facilities will fall into the peer group that matches their geographic location within the state. Facilities classified as ICF/MR or ICF/IMD shall be reimbursed their actual total per diem costs determined prospectively up to a ceiling. The ceiling is set at the 75^{th} percentile of the distribution of costs of the facilities in each class.

An inflation factor (as described in II.I.3 above) will be applied to prior year's costs to determine the current year's rate.

IV. Rate Reconsideration

A. Primary Rate Component

Long-term care providers shall have the right to request a rate reconsideration for alleged patient misclassification relating to the Department's assignment of the case mix classification**.** Conditions for reconsideration are specified in the Department's nursing home appeals process as specified in the long-term care provider manual.

1. Exclusions from Reconsideration

Specifically excluded from patient class reconsiderations are:

- Changes in patient status between regular patient class reviews.
- Patient classification determinations, unless the loss of revenues for a month's period of alleged misclassification equals ten percent or more of the facility's Medicaid revenues in that month.

2. Procedures for Filing

Facilities shall submit requests for reconsiderations within sixty days after patient classifications are provided to a facility. All requests shall be submitted in writing and must be accompanied by supporting documentation as required by the Department.

3. Patient Reclassifications

Any reclassification resulting from the reconsideration process will become effective on the first day of the month following such reclassification.

B. Non-Primary Rate Components

Long-term care providers shall have the right to request a rate reconsideration for any alleged Department miscalculation of one or more non-primary payment rates.

Miscalculation is defined as incorrect computation of payment rates from provider supplied data in annual cost reports.

1. Exclusions from Reconsideration

Specifically excluded from rate consideration are:

- Department classification of cost items into payment centers.
- Peer-group rate ceilings.
- Department inflation adjustments.
- Capital floor and ceiling rate percentiles.

2. Procedures for Filing

Rate reconsiderations shall be submitted within sixty days after payment rate schedules are provided to a facility. All requests shall be submitted in writing and must be accompanied by supporting documentation as requested by the Department.

3. Rate Adjustments

Any rate adjustments resulting from the reconsideration process will take place on the first day of the month following such adjustment. Rate adjustments resulting from this provision will only affect the facility that had rate miscalculations. Payment ceilings and incentive amounts for other facilities in a peer group will not be altered by these adjustments.

C. Waiver of Requirements

The Director of the Division of Medicaid and Medical Assistance may waive, for a limited period, any provision of the State Plan related to "Methods and Standards for Establishing Payment Rates: Prospective Reimbursement System for Long Term Care Facilities", if a circumstance exists that could negatively affect the health, safety and welfare of residents in Delaware if the provision is not waived for a limited period related to the immediate crisis.

V. Reimbursement for Super Skilled Care

A higher rate will be paid for individuals who need a greater level of skilled care than that which is currently reimbursed in Delaware nursing facilities. For patients in the Super Skilled program the rate will be determined as follows:

A summary of each individual who qualified under the Medicaid program's criteria for a "Super Skilled" level of care will be sent to local nursing facilities, which have expressed an interest in providing this level of care. They will be asked to submit bids, within a specific time frame, for their per diem charge for caring for the individual. The Medicaid program will review the bids and select the one that most meets the needs of the patient at the lowest cost.

VI. Reporting and Audit Requirements

A. Reporting

All facilities certified to participate in the Medicaid program are required to maintain cost data and submit reports on the form and in the format specified by the Department. Such reports shall be filed annually. Cost reports are due within ninety days of the close of the state fiscal year. All Medicaid participating facilities shall report allowable costs on a state fiscal year basis, which begins on July 1 and ends the following June 30. The allowable costs recognized by Delaware are those defined by Medicare principles.

In addition, all facilities are required to complete and submit an annual nursing wage survey on a form specified by the Department. All facilities must provide nursing wage data for the time periods requested on the survey form.

For patients in the Super Skilled program, annual Super Skilled bids will be considered the cost report for Super Skilled services. The nursing facility cost report must be adjusted to reflect costs associated with care for Super Skilled patients.

Failure to submit timely cost reports or nursing wage surveys within the allowed time periods when the facility has not been granted an extension by the Department, shall be grounds for suspension from the program. The Department may levy fines for failure to submit timely data as described in Section II.D. of the General Instructions to the Medicaid nursing facility cost report.

B. Audit

The Department shall conduct a field audit of participating facilities, in accordance with Federal regulation and State law**.** Both cost reports and the nursing wage surveys will be subject to audit.

Overpayments identified and documented as a result of field audit activities, or other findings made available to the Department, will be recovered. Such overpayments will be accounted for on the Quarterly Report of Expenditures as required by regulation.

Rate revisions resulting from field audit will only affect payments to those facilities that had an identified overpayment. Payment ceilings and incentive payments for other facilities within a peer group will not be altered by these revisions.

C. Desk Review

All cost reports and nursing wage surveys shall be subjected to a desk review annually. Only desk reviewed cost report and nursing wage survey data will be used to calculate rates.

VII. Reimbursement for Out-of-State Facilities

Facilities located outside of Delaware will be paid the lesser of the Medicaid reimbursement rate from the state in which they are located or the highest rate established by Delaware for comparably certified non-state operated facilities as specified above.

VIII. Reimbursement of Ancillary Service

For Peer Groups A and B:

Oxygen, physical therapy, occupational therapy, and speech therapy will be reimbursed on a fee-for-service basis. The rates for these services are determined by a survey of all enrolled facilities' costs. The costs are then arrayed and a cap set at the median rate. Facilities will be paid the lower of their cost or the cap. The cap will be recomputed every three years based on new surveys.

The Delaware Medicaid Program's nursing home rate calculation, the Patient Index Reimbursement System, complies with requirements found in the Nursing Home Reform Act and all subsequent revisions. A detailed description of the methodology and analysis used in determining the adjustment in payment amount for nursing facilities to take into account the cost of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident eligible for benefits under Title XIX is found in Attachment A.

For Peer Group C:

Ancillary Services are included in the per diem reimbursement.

IX. Reimbursement for Pediatric Nursing Facility Care

Certain Medicaid-eligible children under the age of 21 years require facility-based nursing care and would be best served in a specialized pediatric nursing facility (that is, other than a traditional nursing facility). In order to qualify for this care, clients must be determined to require this level of care by the DMMA Medical Evaluation Team.

The level of reimbursement for each client will be based on the level of care determined by the DMMA Medical Evaluation Team. A per diem rate shall be established for each level of care based on reasonable costs for comparable DMMA services that have a demonstrated cost history and that serve a similar population, adjusted as necessary to reflect substantive differences in program operation. Rates for each level of care shall be computed for a base year and may be inflated each year thereafter using a nationally recognized inflation index. In addition to all nursing and operational costs, per diem rates are inclusive of all services, including but not limited to all therapies, supplies, non-custom durable medical equipment and over-the-counter (OTC) drugs required to treat the child's medical condition but do not include custom durable medical equipment for the individual use of a client or prescription ("legend product") drugs, which will be billed directly to Medicaid by the appropriate medical care provider in accordance with Medicaid policy. Clients assessed as requiring the higher level of care may also receive a supplemental per diem payment for ventilator care.

Eligible children in Pediatric Nursing Facilities located outside of Delaware are reimbursed at the lowest Delaware Pediatric Nursing Facility rate for each client category level to which they are assigned after being assessed by the DMMA Medical Evaluation Team.