DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

FINAL

ORDER

Title XIX Medicaid State Plan Attachment 4.19-D Reimbursement Methodology for Nursing Facilities

Nature of the Proceedings

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Title XIX Medicaid State Plan regarding the reimbursement methodology for nursing facilities. The Department's proceedings to amend its regulations 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 October 2007 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 31, 2007 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary of Proposed Amendment

Statutory Authority

- 42 CFR Part 447, Subpart B – *Payment Methods- General Provisions*;
- 42 CFR Part 447, Subpart C – *Payment for Inpatient Hospital and Long-Term Care Facility Services*; and,
- 42 CFR §447.205, *Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates*.

Summary of Proposed State Plan Amendment

The purpose of this amendment is to update the Prospective Reimbursement System for Long Term Care Facilities to be consistent with the policies of the Division of Medicaid and Medical Assistance (DMMA). DMMA is not changing existing policies or procedures, but clarifying the Medicaid State Plan to reflect current practices, as follows:

- To clarify the designations of Peer Groups consistently throughout Attachment 4.19-D.
- To allow public facilities to be included in Peer Groups A or B at the discretion of the Medicaid Director. This allows a public facility to be established as an individual per diem rate in Peer Groups A or B.
- To clarify existing regulatory language referring to Peer Group C's rate methodology.
- To provide language explaining the Medicaid Director's right to waive any provision of Attachment 4.19-D if it is necessary to ensure the health and safety of nursing facility residents.

The provisions of this amendment are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Summary of Comments Received with Agency Response

The Delaware Developmental Disabilities Council (DDDC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendation summarized below. DMMA has considered each comment and responds as follows.

First, the Division establishes its discretionary authority for creating rates for public facilities. The regulation provides DMMA with the option of either: 1) including public facilities with private facilities when compiling cost information to arrive at a base rate; or 2) simply using public facility costs to arrive to at a base rate. At 428-429.

This discretion would ostensibly benefit the State which could then adopt the approach most financially beneficial to public facilities. SCPD endorses this discretion.

Agency Response: DMMA thanks you for the endorsement.

Second, the DMMA Director is granted the authority to waive State Plan reimbursement limits "if a circumstance exists that could negatively affect the health, safety and welfare of residents in Delaware if the provision is not waived." At page 439. This concept is similar to one endorsed by the Council authorizing the State to provide additional reimbursement to pediatric nursing homes to assure that a child's health status is not jeopardized." See commentary at 11 DE Reg. 314 (September 1, 2007). My only concern with the proposed language is that it is literally limited to "residents in Delaware". Sections VII (p. 441) and IX (p. 442) contemplate reimbursement to out-of-state facilities (e.g. Vorhees). To ensure that the DMMA Director's authority to waive standards could extend to out-of-state facilities, it would be preferable to substitute "facility residents" for "residents in Delaware". This would achieve consistency with Section IX which grants DMMA the option of providing additional reimbursement to both in-state and out-of-state facilities.

Agency Response: The creation of a "waiver" process to enable DMMA to waive specific provisions of the rate setting process for long term care facilities is intended to allow the Medicaid Director to take into account circumstances where the application of existing reimbursement rules could have an unintended negative impact on the health and safety of Delaware's Medicaid recipients. Our intent was that the provision applies to Delaware Medicaid recipients, including individuals who are receiving services in other states. We will take your comment under consideration when the State Plan Amendment is submitted to CMS.

Findings of Fact

The Department finds that the proposed changes as set forth in the October 2007 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Title XIX Medicaid State Plan regarding the reimbursement methodology for nursing facilities is adopted and shall be final effective December 10, 2007.

Vincent P. Meconi, Secretary, DHSS, November 14, 2007

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

STATE PLAN AMENDMENT 4.19-D

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. ~~A schedule of primary rates, including rate additions, is established for each of three groups of facilities:~~ 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:

- ~~Private facilities in New Castle County~~
- ~~Private facilities in Kent and Sussex Counties~~
- ~~Public facilities~~

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 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 Bathing, Eating, Mobility/Transfer/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 or range of scores.

   Each patient classification is related to specific nursing time factors. These time factors are multiplied by the 75th 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 six month and one-year 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 ~~private facilities in New Castle County, private facilities in Kent and Sussex Counties, and public facilities statewide.~~ 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 private facilities and October 1 through September 30 for State facilities.~~ 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 ~~three provider groups (private facilities in New Castle County, Kent and Sussex Counties, and public facilities),~~ 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 rehabilitation/preventive program as defined and approved by the Department shall be reimbursed an additional 10% of the rehabilitative/preventive 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 ~~private facilities and October 1 through September 30 for State facilities~~. 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). ~~Three steps~~ 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~~ 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 ~~rates~~ 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 ~~private facilities~~ Peer Groups A and B and October 1 through September 30 for ~~public facilities~~ Peer Group C. ~~ICF/MR and ICF/IMD facilities shall be reimbursed actual total per diem costs determined prospectively up to a ceiling. The ceiling is set at the 75th percentile of the distribution of costs of the facilities in each class. There are four (4) classes of facilities, which are:~~ 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 75th percentile of the distribution of costs of the facilities in each class.

An inflation factor (as described in II.~~H~~.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 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.

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 Private Facilities~~

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.

Eligible recipients meeting the eligibility criteria for pediatric nursing facility care but who are being cared for in a facility other than a Pediatric Nursing Care Facility shall be reimbursed at the lowest appropriate Pediatric Nursing Facility rate after an assessment by the DMMA Medical Evaluation Team.

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.

In special cases, the State has the option to provide additional reimbursement if circumstances warrant, where such additional reimbursement is necessary to ensure that the appropriate level of care is given to assure that the child's health status is not jeopardized.

11 DE Reg. 792 (12/01/07) (Final)