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

Reimbursement Methodologies for Inpatient Psychiatric Hospital Services and Outpatient Hospital Services

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Title XIX Medicaid State Plan regarding Payment Methodologies for Inpatient Psychiatric Hospital Services and Outpatient Hospital Services. 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 December 2012 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 31, 2012 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

Pursuant to the public notice requirements of Social Security Act §1902(a)(13)(A) and 42 CFR §447.205, the Division of Medicaid and Medical Assistance (DMMA) publishes this notice of significant changes in the reimbursement methodologies for Inpatient Psychiatric Hospital Services and Outpatient Hospital Services.

Statutory Authority

- Social Security Act §1902(a)(13)(A), Public process for determination of rates of payment;
- 42 CFR §440.20, Outpatient Hospital Services and Rural Health Clinic Services;
- 42 CFR §440.40, Nursing Facility Services for Individuals Age 21 or Older (other than services in an institution for mental disease), EPSDT, and Family Planning Services and Supplies;
- 42 CFR §440.160, Inpatient Psychiatric Services for Individuals Under Age 21;
- 42 CFR Part 447, Payment for Services;
- 42 CFR §447.205, Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates

Summary of Proposal

Background

As part of the Companion Letter process to Delaware SPA #08-004, School-Based Health Services, the Centers for Medicare and Medicaid Services (CMS) required additional information regarding the reimbursement methodology for Prescribed Pediatric Extended Care (PPEC) services; specifically, how the cost reports were used to create rates for the three levels of care (LOC). That information is no longer available. In these circumstances, CMS has directed states to indicate the effective date for the rates and requires that the fee schedule be published on the State's Delaware Medical Assistance Program (DMAP) website.

Proposal

Currently, the Division of Medicaid and Medical Assistance (DMMA) pays providers of inpatient psychiatric hospital services and partial hospital psychiatric services based on individually negotiated rates with each provider. CMS has indicated that such negotiated rates are not consistent with efficiency, economy and quality of care as required by Section 1902(a)(30)(A) of the Social Security Act. The proposed methodologies are based on the Medicare rates for the aforementioned services.

DMMA proposes to implement the changes to the methods and standards for setting payment rates effective January 1, 2013. Medicaid State Plan language on Attachment 4.19-A.1 and Attachment 4.19-B, Page 1b is revised to make this change. No change in payment for PPEC services will result from this regulatory action, so there is no change to the PPEC reimbursement language in the State Plan.

The provisions of these state plan amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact Statement

With a fairly small fiscal impact, this change in rates for private psychiatric hospital services will bring Delaware into

compliance with federal reimbursement principles, will pay rates that will be consistent across providers and that will enable Delaware to meet the federal upper payment limit tests for inpatient and outpatient hospital services.

No change is proposed for the PPEC rates, so there is no fiscal impact.

Projected fiscal impacts:

Inpatient Psychiatric Hospital rates:

	Fiscal Year 2013	Fiscal Year 2014
General (State) funds	$21,272	$42,805
Federal funds	$26,714	$53,169

Partial Hospitalization Psychiatric rates:

	Fiscal Year 2013	Fiscal Year 2014
General (State) funds	$4,569	$9,195
Federal funds	$5,738	$11,421

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

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. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

As background, DMMA notes that it has been paying providers of inpatient psychiatric services and partial hospital psychiatric services an "individually negotiated rate with each provider". CMS has disallowed this methodology and the Division is now adopting a more uniform rate for private providers of these services using Medicare rates as a point of reference. The Division recites that the new methodology will have "a fairly small fiscal impact". At 598. The actual rate calculation standards are detailed and "technical". At 599.

Since it appears the initiative is prompted by CMS and there is little fiscal impact, GACEC and SCPD endorse the proposed regulation subject to a minor grammatical edit. In the first sentence on page 599, insert "at" prior to "42 CFR 413".

Agency Response: DMMA agrees to insert "at" prior to "42 CFR 413" and thanks the Councils for their endorsement.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the December 2012 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to update the Title XIX Medicaid State Plan regarding Payment Methodologies for Inpatient Psychiatric Hospital Services and Outpatient Hospital Services is adopted and shall be final effective February 10, 2013.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATIONS #13-01
REVISIONS:

ATTACHMENT 4.19-A.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT PSYCHIATRIC HOSPITAL CARE

~~Psychiatric Hospital reimbursement is a prospectively set per diem rate based on annually reported costs, not to exceed the Medicare rate for the same service. The rates are calculated by determining the previous year's total allowable cost (as defined by HIM-15) divided by the total number of patient bed days. The rates are recalculated annually for the reimbursement year (October 1 through September 30) and inflated using the inflation indices described in ATTACHMENT 4.19-D, Section I.3, which is obtained annually from the Department of Economics of the University of Delaware.~~

~~**Disproportionate Share Payments - Psychiatric Hospitals**~~

~~Psychiatric hospitals which serve a disproportionate share of low-income patients are eligible for a disproportionate payment adjustment when sixty percent (60%) or more of service revenue is attributable to any combination of the following:~~

- ~~public funds, excluding Medicare and Medicaid~~
- ~~bad debts~~
- ~~free care~~

~~All psychiatric hospitals which meet the criteria will receive payment based at the rate of 90% of uncompensated care. Uncompensated care shall be calculated quarterly and disproportionate share payments authorized at the end of each quarter.~~

~~The psychiatric hospital definition meets the exception under 1923(d)(2) of the Social Security Act.~~

~~Outlier payments under Section 302(b) of the Medicare Catastrophic Coverage Act are not applicable to this class of provider.~~

~~Total payments under this plan will not exceed the Federally published Disproportionate Share Hospital allotment.~~

Reimbursement for public psychiatric hospitals is a prospectively set per diem rate based on annual reported allowable costs, using Medicare cost principles codified 42 CFR 413 and in the Medicare Provider Reimbursement manual (CMS-Pub.15) and consistent with OMB Circular A-87. The rate is computed by determining the previous year's total allowable cost divided by the total number of patient bed days. The rate is recalculated annually for the reimbursement year (October 1 through September 30) and inflated using the inflation indices described in Attachment 4.19-D, page 13. The per diem rate is not cost settled but is limited to the upper payment limit defined below.
Reimbursement for private psychiatric hospitals for inpatient psychiatric hospitalization services is paid as a per diem equal to 93% of the Medicare Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) rate for Delaware.

Reimbursement for inpatient psychiatric hospitalization shall not exceed the upper limit as defined at 42 CFR 447.272. The upper limit is defined as the Medicare IPFPPS rate for Delaware inpatient psychiatric facilities.

No supplemental payments are made for public or private inpatient psychiatric hospital services.

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both government and private providers. The fee schedule and any annual/periodic adjustments to the fee schedule are available on the DMAP website at: http://www.dmap.state.de.us/downloads.

(Break in Continuity of Sections)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OUTPATIENT HOSPITAL CARE

Hospital Specific Cost-to-Charge Ratios – Hospital specific cost-to-charge ratios were calculated for each hospital for defined groupings of revenue codes (for example, blood or anesthesia), not including the visit services above, based on charges and costs for outpatient services reported by each hospital for the base period (1992). Each Delaware hospital is paid based on a hospital specific~~%~~ percentage of billed charges for these revenue codes.

Reimbursement for private psychiatric hospitals for partial hospital psychiatric services is paid at 100% of the Medicare Hospital Outpatient Prospective Payment System (OPPS) per diem rates for Hospital-Based Level 1 and Level II Partial Hospitalization Program (PHP) services.

Supplemental payments are not made for outpatient hospital services. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both government and private providers. ~~The visit rates, the outpatient percent of charges and the fee schedule for laboratory services~~ Fee schedules for outpatient hospital services including laboratory services are available on the DMAP website at: http://www.dmap.state.de.us/downloads.

Outpatient Hospital UPL Methodology

UPL demonstrations are performed by applying the Medicare outpatient cost to charge ratios from the Medicare Cost

Report to the provider's billed charges as recorded in Delaware's MMIS to calculate the Medicare payment. For UPL demonstrations for services not covered by Medicare, ~~DE~~ Delaware uses the Medicaid State Plan Fee Schedule rate as the reasonable estimate of what Medicare would have paid. Crossover claims are excluded from the demonstration.

Data required to perform the UPL test includes the following: Medicare Outpatient Cost to Charge Ratio – Worksheet c, Part I, Lines 37-61 from the most recently available Medicare Hospital Cost Report (CMS-2552-96) and hospital outpatient fee for service Billed Amount and Allowed Amount from Delaware MMIS for paid claims by date of service that corresponds to the Medicare Hospital Cost Reporting period for each Delaware hospital. The appropriate Medicare outpatient hospital cost category will be determined for each corresponding Delaware Medicaid Level of Reimbursement (grouping of like revenue codes). For each provider, the Medicare Cost to Charge Ratio for each Delaware Medicaid Level of Reimbursement is multiplied by the billed amount submitted by the provider to determine Medicare-defined cost. The results are compared to Delaware Allowed Amount as recorded in the MMIS. The "Allowed Amount" is the maximum allowable payment per Delaware outpatient reimbursement policy before TPL and other offsets are applied. For claims where there are no offsets, the "Allowed Amount" equals the actual paid amount. The difference between Medicare Cost and Delaware Medicaid Cost for each cost category is computed for each provider and aggregated. If the aggregate Medicare Cost exceeds the Medicaid Cost, then the Upper Payment Limit test is met. If the Medicare Cost is less than the Medicaid Cost, then an overpayment has been made by the amount by which the Medicaid Cost (i.e. Allowed Amount) exceeds the Medicare Cost.

16 DE Reg. 867 (02/01/13) (Final)