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State Name: Delaware

State Plan Amendment (SPA) #09-002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

JAN 24 2011

Rosanne Mahaney, Director
Division of Medicaid & Medical Assistance
Delaware Health and Social Services
1901 N. DuPont Highway
New Castle, Delaware 19720-0906

Dear Ms. Mahaney:

We have reviewed State Plan Amendment (SPA) 09-002, in which you propose to freeze or reduce payment rates for the following provider services: inpatient hospital services, outpatient hospital services, pharmaceutical services, ambulatory surgical services, dental services, and nursing facility care services. This SPA, as modified by your email note dated January 13, 2011, is acceptable. Therefore, we are approving SPA 09-002 with an effective date of April 1, 2009. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Melanie Benning at 215-861-4267.

Sincerely,

[redacted]

Ted Gallagher
Associate Regional Administrator

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **SPA #09-002**	2. STATE **Delaware**
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2009**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN **XXX** AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **1902(r)(2), 1902(a)(10)(A)(ii), and 1905(p)**	7. FEDERAL BUDGET IMPACT: **a. FFY 2009 $ - 1,144,800** **b. FFY 2010 $ - 8,734,400**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A, Pages 1 and 3** **Attachment 4.19-B, Page 1a, b, and c** **Attachment 4.19-B, Page 14** **Attachment 4.19-B, Page 17** **Attachment 4.19-B, Page 19** **Attachment 4.19-D, Page 1**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A, Pages 1 and 3** **Attachment 4.19-B, Page 1a** **Attachment 4.19-B, Page 14** **Attachment 4.19-B, Page 17** **Attachment 4.19-B, Page 19** **Attachment 4.19-D, Page 1**

10. SUBJECT OF AMENDMENT: **Reimbursement Methodology for provider rate adjustments for the following provider services: inpatient hospital services; outpatient hospital services; pharmaceutical services; ambulatory surgical services; dental services; and, nursing facility care services.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
XXX OTHER, AS SPECIFIED: **Governor's comments under separate correspondence**

12. SIGNATURE OF STATE AGENCY OFFICIAL: **//Rosanne Mahaney – signature//**	16. RETURN TO: **Rosanne Mahaney** **Acting Director, Division of Medicaid and Medical Assistance** **P.O. Box 906** **New Castle, Delaware 19720-0906**
13. TYPED NAME: **Rosanne Mahaney, Acting Director, Division of Medicaid and Medical Assistance**	
14. TITLE: **Designee for Rita M. Landgraf, Secretary, Delaware Health and Social Services**	
15. DATE SUBMITTED: **06/30/09**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/30/2009	18. DATE APPROVED: JAN 24 2011
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/2009	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Ted Gallagher	22. TITLE: Associate Regional Administrator

23. REMARKS:

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.

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.

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 Effective April 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.

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

- A prospective flat visit rate for four types of visit services provided as outpatient services
  - Emergency
  - Non-emergency
  - Clinic
  - Labor/Delivery room
- A hospital-specific cost-to-charge ratio for defined groupings of revenue codes for services not included in the visit rates above
- A fee schedule for laboratory services that is paid as a percentage of the Medicare rate.

Reimbursement Methodology

Visit Rates - Hospital cost report data and Medicaid claims data from all Delaware acute care general hospitals from a base year (1992) was collected to be used to determine the actual cost for each Delaware hospital outpatient department for each type of visit. The cost data from all the hospitals except one, A.I. DuPont Hospital for Children was used to establish a single statewide rate (i.e. not a separate rate for each hospital) for each of the four outpatient visit services. Cost report data from A.I. DuPont Hospital for Children was not used in the development of the visit rates, as it is a specialty hospital serving only children and its cost structure was determined to be too different to be included in a statewide rate. This hospital also does not provide labor and delivery service, so no Labor/Delivery rate was necessary. A separate set of visit rates for all but delivery was for developed for the A.I. DuPont Hospital. Since the development of the visit rates based on hospital cost report data, each rate has been indexed forward using the CMS Inpatient Prospective Payment System Index.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF 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 % of billed charges for these revenue codes.

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 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 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OUTPATIENT HOSPITAL CARE

Clinic UPL Methodology

Two separate UPL tests are performed, one for private clinics and one for state-operated clinics. There are no non-state or local-government operated clinics in Delaware.

- Private clinics: Private clinics include: Ambulatory Surgical Centers (ASC), End Stage Renal Disease (ESRD) Clinics, Non-Hospital Affiliated Free Standing Emergency Rooms and Methadone Clinics. ASCs and ESRD clinics are paid a fixed percent of the Medicare rate for those services, 95% and 100% respectively. Medicare does not cover dental, Methadone administration or free standing emergency rooms. For UPL demonstrations for services not covered by Medicare, DE uses the Medicaid State Plan Fee Schedule rate as the reasonable estimate of what Medicare would have paid.
- State-Operated clinics: State-operated clinics include: Public Health Medical Clinics, Public Health Dental Clinics, School-Based Wellness Centers, and Community Mental Health Clinics. With the exception of three procedure codes, the Public Health Medical Clinics are paid via the Delaware Medicaid Physician Fee Schedule, which is a fixed percent of the Medicare Fee Schedule for Delaware. For two of the three other procedure codes, corresponding codes from the Medicare Fee Schedule were determined by a DMMA nurse. Procedure code T1024 relates to developmental screening and treatment of disabled children and is not covered by Medicare. For this code, the Medicaid rate was assumed to be the reasonable estimate of what Medicare would have paid. For the Public Health Dental Clinics, the Medicaid rate was determined to be the reasonable estimate of what Medicare would have paid because Medicare does not cover dental services. For the School-Based Wellness Centers and the Community Mental Health Centers, DMMA used the CMS 222 Cost Report format to record provider costs using Medicare Cost Principles. A Medicare visit rate was computed that could be multiplied by the Medicaid units of service for each fiscal year to determine what Medicare would have paid.

  For both each category of clinic, the computed Medicare-defined cost is compared to the Delaware Allowed Amount, which is the maximum allowable payment per Delaware clinic reimbursement policy before TPL and other offsets are applied. For claims where there are no offsets, the "Allowed Amount" equals the actual paid amount. Calculate difference between Medicare Cost and Delaware Medicaid Cost for each type of clinic. Aggregate the data for category of clinic (private, state and non-state) to determine whether the Medicaid Cost exceeds the Medicare Cost.
  - If no, then the Upper Payment Limit test is met
  - If yes, then an overpayment has been made by the amount by which the Medicaid Cost (i.e. Allowed Amount) exceeds the Medicare Cost

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.

AMENDED STATE PLAN PAGE

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 16% plus dispensing fee per prescription, effective for dates of service on or after April 1, 2009
  - For Non-Traditional Pharmacies: AWP minus 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>

AMENDED STATE PLAN PAGE

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). Effective April 1, 2009, Delaware Medicaid reimburses 95 percent of the Medicare calculated ASC rates for Delaware.

Except as otherwise noted in the plan, State developed rates are the same for both government and private providers. The fee schedule of ASC rates is available on the DMAP website at the following address: http://www.dmap.state.de.us/downloads.

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

1. Dental Treatment - reimburse 80% of billed charges for routine dental services for dates of service on or after April 1, 2009.

2. 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 State pays 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

STATE PLAN AMENDMENT 4.19-D

Payment Methodology Effective April 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.