Table of Contents

State Name: Delaware

State Plan Amendment (SPA) #: 12-014

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

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

SWIFT# 121920124048

MAR 14 2013

Stephen Groff, Acting Director
Division of Medicaid & Medical Assistance
Department of Health & Social Services
1901 N. DuPont Highway
New Castle, Delaware 19720-0906

Dear Mr. Groff:

The Centers for Medicare & Medicaid Services has approved Delaware State Plan Amendment (SPA) 12-014 to change the payment methodology for outpatient hospital services, specifically, partial hospital psychiatric services and Prescribed Pediatric Extended Care (PPEC) services. The effective date of this SPA is January 1, 2013. Enclosed are the approved SPA page and the signed CMS-179 form.

If you have further questions about this SPA, please contact Michael Cleary at 215-861-4282.

.

Sincerely,

[redacted]

Francis McCullough
Associate Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **SPA #12-014**

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
JANUARY 1, 2013

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:
Social Security Act §1902(a)(13)(A)
42 CFR Part 447
42 CFR §447.205

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $ 5,738
b. FFY 2014 $ 11,421

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19-B, Page 1b

10. SUBJECT OF AMENDMENT: **PAYMENT METHODOLOGY FOR OUTPATIENT HOSPITAL SERVICES, SPECIFICALLY, PARTIAL HOSPITAL PSYCHIATRIC SERVICES and PPEC 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:
//Stephen M. Groff – signature//

13. TYPED NAME:
Stephen M. Groff, Deputy Director, Division of Medicaid and Medical Assistance

14. TITLE: **Designee for Rita M. Landgraf, Secretary, Delaware Health and Social Services**

15. DATE SUBMITTED:
December 19, 2012

16. RETURN TO:
Stephen M. Groff
Deputy Director
Division of Medicaid and Medical Assistance
P.O. Box 906
New Castle, Delaware 19720-0906

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
Dec. 19, 2012

18. DATE APPROVED:
MAR 14 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Francis McCullough

22. TITLE:
Associate Regional Administrator/DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

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. 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 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.