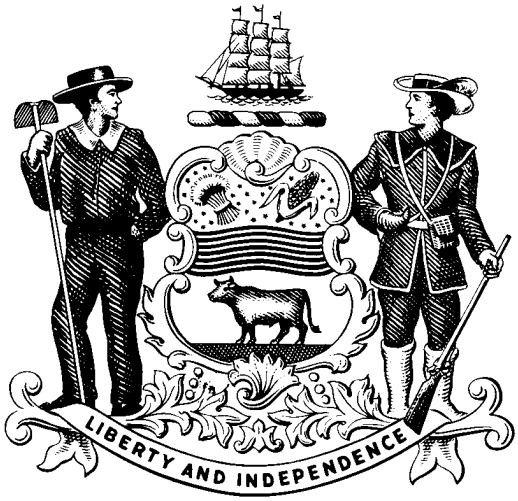
DELAWARE HEALTH RESOURCES MANAGEMENT PLAN



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INTRODUCTION

This Health Resources Management Plan is brought forth at a time when the health care environment is undergoing enormous change. While no sweeping federal legislation resulted from the recent national attention on health care reform, we are witnessing a strengthening of market forces in the health care arena. This has been prompted in large part by the growing dissatisfaction among employers with escalating health care costs. The strengthening of market forces is a major theme in the health care reform strategy adopted by the Delaware Health Care Commission.

Today's health care delivery and financing practices are quite different from those in place in 1975, when the National Health Planning and Development Act was signed into law. This Act required states to establish Certificate of Need (CON) programs, meeting federal specifications, to provide a review of proposed new health facilities and services and major capital expenditures. The law was repealed in 1986, although the vast majority of states have continued CON programs. In Delaware, CON was replaced with Certificate of Public Review (CPR) in June 1999.

With this backdrop, the Delaware Health Resources Board (Board) believes it is best served by a Health Resources Management Plan which embodies flexibility. This will allow the Board to consider changing circumstances unfettered by any allegiance to outdated rigid standards which may have seemed perfectly appropriate just a short time before. This approach magnifies the importance of the guiding principles, which appear in the next

section. In addition to these guiding principles, the Plan includes components which address medical-surgical bed needs, obstetrical bed needs, nursing home bed needs, and medical technology.

A proposal's relationship to the Health Resources Management Plan is one of seven statutory criteria used in reviewing Certificate of Public Review (CPR) applications. Other criteria are (1) the need of the population, (2) the availability of less costly and/or more effective alternatives, including the use of out-of-state resources, (3) the relationship to the existing health care delivery system, (4) the immediate and long term viability, (5) the anticipated effect on costs and charges, and (6) the anticipated effect on quality of care.

The following are important resource documents which may be of interest to the reader:

- **Healthy Delaware 2010**

  Contact: Division of Public Health
  Jesse Cooper Building
  417 Federal Street
  Dover, DE 19901
  Tel. (302) 744-4700

- **A Comprehensive Health Care Reform Strategy**

  Contact: Delaware Health Care Commission
  Thomas Collins Bldg., 1st Floor
  540 S. duPont Hwy.
  Dover, DE 19901
  Tel. (302) 739-6906

- **Delaware Vital Statistics Annual Report**

  Contact: Bureau of Health Planning & Resources Management
  Jesse Cooper Building
  Federal & Water Streets
  417 Federal Street
  Dover, DE 19901
  Tel. (302) 744-4555

- **Hospital Discharge Summary Report**

  Contact: Bureau of Health Planning & Resources Management
  Jesse Cooper Building
  Federal & Water Streets
  417 Federal Street
  Dover, DE 19901
  Tel. (302) 744-4555

- **Population Projections (Delaware Population Consortium)**

  Contact: Bureau of Health Planning & Resources Management
  Jesse Cooper Building
  Federal & Water Streets
  417 Federal Street
  Dover, DE 19901
  Tel. (302) 744-4555

- **Delaware Nursing Home Utilization Statistics**

  Contact: Bureau of Health Planning & Resources Management
  Jesse Cooper Building
  Federal & Water Streets
  417 Federal Street
  Dover, DE 19901
  Tel. (302) 744-4555

- **Study on the Future Directions of Public Nursing Facilities**

  Contact: Division of Public Health
  Jesse Cooper Building
  Federal & Water Streets
  417 Federal Street
  Dover, DE 19901
  Tel. (302) 739-4701

Statement
of
Purpose and Principles

Purpose

"....to assure that there is continuing public scrutiny of certain health care developments which could negatively affect the quality of health care or threaten the ability of health care facilities to provide services to the medically indigent. This public scrutiny is to be focused on balancing concerns for cost, access and quality." This excerpt from the enabling legislation captures the purpose of the Delaware Health Resources Board (the Board).

An important tool in carrying out this purpose is the Health Resources Management Plan (the Plan). Again, quoting from the enabling legislation, the Plan shall ".....assess the supply of health care resources, particularly facilities and medical technologies, and the need for such resources." Further, "A statement of principles to guide the allocation of resources and specific criteria and other guidance for use in reviewing Certificate of Public Review applications shall be essential aspects of the plan."

Principles

The following general principles are intended to assist potential Certificate of Public Review (CPR) applicants in understanding the Board's expectations and also to assist the Board itself in conducting CPR reviews, particularly in matters where specific guidelines are lacking.[1]

1. The essential challenge faced by the Board is striking an appropriate balance in its consideration of access, cost and quality of care issues. Evidence that this challenge has been seriously embraced by the applicant should permeate every CPR application

[1] The Board will always be bound by the enabling statute (16 Del. C., Chapter 93) which statute will apply if inconsistent with this Plan.

2. The problem of medical indigency is extremely complex. The Delaware Health Care Commission continues to provide leadership in this area. CPR applicants are expected to contribute to the care of the medically indigent.

3. Historically, health care delivery has too often been episodic and disjointed. Projects which support a managed, coordinated approach to serving the health care needs of the person/population are to be encouraged.

4. Given Delaware's small size and close proximity to major metropolitan referral centers, particularly in Philadelphia and Baltimore, every health care service need not be available within its borders. Potential CPR applicants are expected to take into account the availability of out-of-state resources.

5. Historically, our cost-based reimbursement system has provided little incentive for financial restraint; over-utilization has been encouraged. Revenue centers, not cost centers, were generally emphasized. Projects which reflect or promote incentives for over-utilization (including self-referral) are to be discouraged.

6. Strengthening market forces is a central theme in the health care reform strategy adopted by the Delaware Health Care Commission, a theme which is embraced by the Board. Projects resulting from or anticipated to enhance meaningful markets are to be encouraged. In the past, "competition" has often been on the basis of amenities for physicians (the medical arms race) and patients (the plushest waiting room). In meaningful markets there must be sensitivity to elements of both cost and quality.

7. Prevention activities such as early detection and the promotion of healthy lifestyles are essential to any effective health care system. Healthy Delaware 2010 identifies a number of opportunities to improve the health status of Delawareans. The potential for a project to bring about progress in these areas will be viewed as a very positive attribute.

MEDICAL/SURGICAL BED NEEDS

The following guidelines will be used during Certificate of Public Review reviews for new, expanded or renovated inpatient medical/surgical facilities.

Guideline 1 – Additional Facilities

No additional hospitals offering medical/surgical beds shall be established in Delaware over the next five years.

Guideline 2 - Current Occupancy Rate

A hospital applying for additional medical/surgical beds shall be expected to have experienced an actual medical/surgical occupancy rate during the base year of at least 90 percent based on approved bed capacity.

Guideline 3 - Medical/Surgical Bed Projections

a. Hospital-Specific - Estimated needs for medical/surgical beds shall be calculated in the following manner for each hospital in Delaware which has medical/surgical beds.

Step 1

Calculate the average daily census (ADC) in the base year by dividing the base year patient days by 365.

BASE YEAR ADC = BASE YEAR PATIENT DAYS ÷ 365

Step 2

Calculate the projected ADC by multiplying the base year ADC by a "population change factor" (PCF).

PROJECTED ADC = BASE YEAR ADC x PCF

The PCF shall represent a weighted average of projected population changes in the 15-64 age category and the 65+ age category. Weights will be based on the estimated percentage of medical/surgical patient days in each of the age categories. An example, using fictitious data follows:

EXAMPLE

Age Category	Percentage Med/Surg Patient Days		1990-1995 Population Change		Weights
15-64	40	x	1.05	=	42
65+	60	x	1.10	=	66
					108

PCF = 108/100

PCF = 1.08

If the base year ADC as calculated in Step 1 is less than 95 percent of the ADC in the previous base year, a PCF of 1.0 will be used unless the PCF as calculated is less than 1.0, in which case the lesser figure will be used.

Step 3

Calculate the projected bed need by dividing the ADC by an occupancy factor of .875.

PROJECTED BED NEED = PROJECTED ADC ÷ .875

b. Area Projection - For New Castle County, an area need for medical/surgical beds shall be calculated using the above steps except that in Step 3 an occupancy factor of .85 will be used. Applications from hospitals in New Castle County will be evaluated in light of both hospital-specific and area bed-need projections.

c. Notes Regarding Projections

- Projections will be for five years and be updated annually, based on the most recently available calendar year utilization data (the base year).

- Population changes will be based on the estimates and projections published by the Delaware Population Consortium, except when superseded by more recent estimates of the U.S. Bureau of the Census. Population changes used in the hospital-specific bed projections shall be calculated using the following geographic areas:

  Wilmington Hospital- New Castle County
  Christiana Hospital - New Castle County
  St. Francis Hospital - New Castle County
  Kent General Hospital - Kent County
  Milford Memorial Hospital - Kent and Sussex Counties
  Beebe Medical Center - Sussex County
  Nanticoke Hospital - Sussex County

- In reviewing Certificate of Public Review applications, the bed projections should not be considered so rigidly as to hamper practicality. A reasonable number of beds beyond the projected need for a hospital should not be considered to be inconsistent with this guideline if it promotes greater efficiency. Likewise, proposed additions of a small number of beds which cannot be operated efficiently should not be construed as being consistent with this guideline even though the proposed number of additional beds is within the bed need range. Other unique circumstances may be considered as well.

- Factors other than expected population changes (these are accounted for in the projection formula), which can reasonably be expected to have a material increasing or decreasing effect on utilization should be considered in reviewing Certificate of Public Review applications.

- In reviewing Certificate of Public Review applications, if there is clear evidence that substantial inappropriate utilization is reflected in the base year patient days, this factor can be used to negate a projected need for additional beds.

d. Application - The table below shows the bed need projections using the above methodology. The approved bed supply and the net projected shortage or surplus of beds is also shown along with the 2005 percentage of occupancy based on approved bed supply.

Hospital-Specific	2010 Bed Need	Approved Bed Supply	Shortage (Surplus)	2005 % Occ.
Christiana Hospital	803	703	100	92.6
Wilmington Hospital	207	245	(38)	135.0
St. Francis	120	298	(178)	32.6
Kent General	238	183	55	100.0
Milford	131	108	23	93.5
Beebe	131	210	(79)	48.2
Nanticoke	111	110	1	76.8
Area-Wide				
New Castle County	1165	1246	(81)	81.4

OBSTETRICAL BED NEEDS

The following guidelines will be used during Certificate of Public Review reviews for new, expanded or renovated inpatient obstetrical facilities.

Guideline 1 - Additional Facilities

No additional hospitals offering obstetrical beds shall be established in Delaware over the next five years.

Guideline 2 - Obstetrical Bed Projections

a. Hospital - Specific - Estimated needs for obstetrical beds shall be calculated in the following manner for each hospital in Delaware which has obstetrical beds.

Step 1

Calculate the average daily census (ADC) for the base period (most recent 3 calendar years) by dividing the base period patient days by 1095 (number of days in base period).

BASE PERIOD ADC = BASE PERIOD PATIENT DAYS ÷ 1095

Step 2

Calculate the projected ADC by multiplying the base period ADC by a "population change factor" (PCF).

PROJECTED ADC = BASE PERIOD x PCF

The PCF shall represent the projected population changes in the 15-44 female age category.

Step 3

Calculate the projected bed need by adding to the projected ADC the product of 1.65 times the square root of the projected ADC.

PROJECTED BED NEED $= \text{Pr}ojected\ ADC + 1.65\sqrt{\text{Pr}ojected\ ADC}$

b. Area Projection - For New Castle County, an area need for obstetrical beds shall be calculated using the above steps except that in Step 3 the projected ADC will be increased by the product of 2.33 times the square root of the projected ADC in order to arrive at the projected bed need. Applications from hospitals in New Castle County will be evaluated in light of both hospital-specific and area bed need projections.

c. Notes Regarding Projections

- The 1.65 and 2.33 confidence intervals are derived from statistical theory and provide for a 95 percent probability and a 99 percent probability respectively of a bed being available.

- Projections will be for five years and be updated annually, based on utilization data for the most recently available three calendar years (the base period).

- Population changes will be based on the estimates and projections published by the Delaware Population Consortium, except when superseded by more recent estimates of the U.S. Bureau of the Census. Population changes used in the hospital-specific bed projections shall be calculated using the following geographic areas:

  Christiana Care - New Castle County
  St. Francis Hospital - New Castle County
  Kent General Hospital - Kent County
  Milford Memorial Hospital - Kent and Sussex Counties
  Beebe Medical Center - Sussex County
  Nanticoke Hospital - Sussex County

- In reviewing Certificate of Public Review applications, the bed projections should not be considered so rigidly as to hamper practicality. A reasonable number of beds beyond the projected need for a hospital should not be considered to be inconsistent with this guideline if it promotes greater efficiency. Likewise, proposed additions of a small number of beds which cannot be operated efficiently should not be construed as being consistent with this guideline even though the proposed number of additional beds is within the bed need range. Other unique circumstances may be considered as well.

- Factors other than expected population changes (these are accounted for in the projection formula), which can reasonably be expected to have a material increasing or

decreasing effect on utilization should be considered in reviewing Certificate of Public Review applications.

- In reviewing Certificate of Public Review applications, if there is clear evidence that substantial inappropriate utilization is reflected in the base year patient days, this factor can be used to negate a projected need for additional beds.

d. Application - The table below shows the bed need projections using the above methodology. The approved bed supply and the net projected shortage or surplus of beds is also shown.

	2010	Approved	
Hospital Specific	Bed Need:	Bed Supply	Shortage or (Surplus)
Christiana Care	79	158	(79)
St. Francis	10	24	(14)
Kent General	19	27	(8)
Milford Memorial	7	9	(2)
Beebe	9	12	(3)
Nanticoke	9	8	1
Area Wide			
New Castle County	92	182	(90)

NURSING HOME BED NEEDS

The review of nursing home beds (skilled and intermediate care) represents a significant portion of review activities which are conducted pursuant to the Certificate of Public Review program. The following guidelines are instrumental in carrying out these activities.

Consistency with the projected bed needs derived from Guideline l shall serve as a "threshold" to be met in order for a Certificate of Public Review to be granted for additional nursing home beds. When this "threshold" is met, the favorable attributes set forth in Guideline 3 shall also be considered.

Guideline 1 - Nursing Home Bed Projections

a. Method - Estimated needs for beds in Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF) shall be calculated in the following manner.

STEP 1

Calculate the average daily census (ADC) in the base year by dividing the base year patient days by 365.

BASE YEAR ADC = BASE YEAR PAT. DAYS ÷ 365

STEP 2

Calculate the projected ADC by multiplying the base year ADC by a "population change factor" (PCF).

PROJECTED ADC = BASE YEAR ADC x PCF

The PCF shall represent a weighted average of projected population changes in the following age categories:

- less than 65
- 65 through 74
- 75 through 84
- 85 and over

Weights will be based on the estimated percentage of nursing home patients in the above age categories. An example, using fictitious data follows:

EXAMPLE

Age Category	Percentage Nursing Home Admissions		Three-Year Population Growth		Weights
<65	6.7	x	1.042	=	6.98
65-74	16.6	x	1.071	=	17.78
75-84	42.5	x	1.169	=	49.68
85+	34.2	x	1.180	=	40.36
	100.0			114.42	

PCF = 114.42/100.0

PCF = 1.1442

If the base year ADC as calculated in Step 1 is less than the ADC in the previous year and if the percentage of occupancy in private nursing homes in the base year is less than 95%, a PCF of 1.0 will be used unless the PCF as calculated is less than 1.0 in which case the lesser figure will be used.

STEP 3

Calculate the projected bed need by dividing the projected ADC by .90 (desired occupancy rate).

PROJECTED BED NEED = PROJECTED ADC ÷ .90

b. Patient Days - Total annual patient days for ICF and SNF care in both State and private facilities, for the most recent calendar year, are used.

Patient days in State facilities are allocated to each county planning area based on the percentage of patient origin.

c. Population Estimates and Projections - Population estimates and projections published by the Delaware Population Consortium are used, except when superseded by more recent estimates of the U.S. Bureau of Census.

d. Desired Occupancy Rate - The desired occupancy rate used to project the need for ICF/SNF beds in each county planning area is 90%.

e. Planning Areas - The three counties of Delaware (New Castle, Kent and Sussex) are used as planning areas for long term care facility needs.

f. Margin of Error - It must be recognized that estimating future needs for nursing home beds cannot be accomplished with the precision which the use of a mathematical formula often implies. While such formulae are essential, planning requires more than mathematical calculations. Thoughtful judgement must occur. The emphasis which Delaware's Certificate of Public Review statute places on the use of the Delaware Health Resources Board seems to amply demonstrate an intent for "reasoned conclusions." Mathematical rigidity should not inhibit such "reasoned conclusions" from providing a basis for decision making.

Therefore, at the time the bed projections are calculated, the Board may adjust the projection upward or downward by not more than ten percent, when it is concluded that the formula is likely to overestimate or underestimate bed need. For instance if capacity has been so restrained that the base year average daily census is felt to understate legitimate demand, an upward adjustment could be made. If financial access to nursing homes was threatened as a result of a change in Medicaid reimbursement policy, a downward adjustment might be in order. These

are just two examples of the types of factors which might indicate an adjustment should be made.

It should also be recognized that to the extent new uses are proposed for nursing home beds, the need for such beds must be evaluated based on the merits demonstrated during the review of specific Certificate of Public Review applications. An example of such a "new use" might be the provision of skilled or intermediate nursing care for AIDS patients.

g. Frequency of Projections - The demand for long term care beds is assumed to be responsive to several changing factors, such as the availability and accessibility of non-institutional services. Therefore, the three-year projections of long term care bed need will be revised annually, shortly after the publication of annual utilization statistics.

h. Allocation of State Bed Supply - The State long term care facilities are located in New Castle and Kent Counties. However, as State facilities, they are available to all State residents. The supply of State beds is therefore allocated to each of the three counties according to the percentage patient origin. A major report “Study on the Future Directions of Public Nursing Facilities,” was completed in March, 1993 by KPMG Peat Marwick. Among other things, the study recommends that the number of State beds be significantly reduced and that they be directed toward patients most difficult to serve in the private sector, such as those whose behavior require special accommodations, those with infectious diseases and others with special needs.

i. Application - The table below shows the bed need projections using the above method. The existing supply, which includes both existing beds and beds for which Certificates of Public Review have been granted, is also shown along with the projected shortage or surplus of beds. Staffing shortages, especially when coupled with inadequate

reimbursement levels, causes difficulties in placing patients despite an adequate bed supply.

	2015 Need	Approved Supply	Shortage (Surplus)
New Castle County	3333	3019	314
Kent County	876	794	82
Sussex County	1621	1397	224
Totals	5830	5210	620

INVENTORY

	Current # Beds	Future # Beds Approved
New Castle County		
Arbors at New Castle	120	120
Brandywine Convalescent	169	169
Broadmeadow	120	140
Cadia Pike Creek	130	130
Churchman Village	101	101
Cokesbury Village	45	84
Forwood Manor	72	72
Foulk Manor North	46	46
Foulk Manor South	57	57
Gilpin Hall	96	96
Hillside Center	106	106
Jeanne Jugan Residence	40	40
Kentmere Nursing	104	106
Manor Care – Pike Creek	167	167
Manor Care – Wilmington	138	138
Masonic Home of Delaware	25	25
Methodist Country House	60	60
Millcroft	110	110
Newark Manor	67	67
Parkview Nursing & Rehab	150	150
Regal Heights Health Care	172	172
Regency Healthcare & Rehab	100	100
Shipley Manor	82	82
St. Francis Care Center	104	104
Stonegates	49	49
The Milton & Kutz Home	90	90
	2520	2581
Kent County		
Capitol	120	120
Courtland Manor	70	78
Delaware Veterans Home	120	120
Pinnacle Rehab	151	151
Silver Lake	120	120
Westminster Village	61	61
	642	650

	Current # Beds	Future # Beds Approved
Sussex County		
Atlantic Shores	181	181
Cadbury @ Lewes	40	40
Country Rest	56	56
Delmar Nursing & Rehab	109	109
Harbor Healthcare	179	179
Harrison House of Georgetown	109	139
Lewes Convalescent	89	89
Lifecare at Lofland Park	110	110
Methodist Manor House	60	88
Milford Center	136	136
Renaissance Healthcare	130	130
Seaford Center	124	124
	1323	1353
State Facilities		
DE. Hospital for the Chronically Ill	397	397
Delaware Psychiatric Center	35	35
Emilly P. Bissell Hospital	100	100
Governor Bacon	94	94
	626	626
Allocation of State Beds		
New Castle County	438	438
Kent County	144	144
Sussex County	44	44
	626	626
County Totals		
New Castle	2958	3019
Kent	786	794
Sussex	1367	1397
	5111	5210

Guideline 2 - Favorable Attributes

The following will be seen as favorable attributes when reviewing proposed nursing home projects:

- Linkages with hospitals, clinics, home health agencies, pastoral services, social services, etc. in order to foster continuity of care.

- A willingness to serve Medicaid patients.

- Replacing facilities not conforming with current standards.

- Bed complements of at least 100 beds, especially increases in the bed complements of smaller facilities which result in at least 100 total beds.

MEDICAL TECHNOLOGY

This document is intended to assist the Delaware Health Resources Board (Board) in its review of Certificate of Public Review (CPR) applications involving new and emerging medical technology (new and emerging in terms of its use in Delaware, not necessarily from the standpoint of its scientific development). It is also intended to set out for the provider community, a set of expectations concerning the introduction and diffusion of medical technology in the state.

As used in this paper, medical technology refers to devices (major medical equipment) and procedures (health services). Pharmaceuticals are largely regulated at the federal level and while responsible for many advances in health care, are generally not of concern with respect to the Certificate of Public Review program.

As pointed out by Health Systems Research, Inc. (HSR), the consulting firm which was engaged by the Board's predecessor, the Health Resources Management Council, "Medical technology has long been a subject of concern for all members of the health care community -- providers, consumers, researchers and policy makers. Attention has focused on achieving an appropriate balance across three sometimes consistent, but oftentimes conflicting, objectives: ensuring access to innovative technology, controlling the costs associated with this new technology, and ensuring that the extent of a technology's diffusion does not adversely affect quality of care." A brief discussion of each of these concerns follows:

- Access - In today's world there is enormous pressure not only from the medical community but also the general public (as a result of extensive coverage by the mass media) to have access to the very latest in cutting-edge technology.

- Cost - Technological advances can affect costs both favorably and unfavorably. For instance, from a positive standpoint the technology might replace a more expensive procedure, eliminate hospitalization, reduce length of stay, or improve outcome so as to eliminate future direct or indirect costs of an illness. On the other hand, the technology might increase costs as a result of incurring a new capital expenditure, supplementing (rather than replacing) current technology, causing the demand for treatments that otherwise would not be considered, producing side effects that need to be treated or extending life even in cases with no expectation of improved quality of life or recovery.

- Quality - While the development of new medical technologies can generally be viewed as favorably affecting the quality of care, there is reason to believe that the excessive diffusion of certain technologies actually has a negative influence on quality. For instance, with open heart surgery, there is an association between lower surgical volumes (about 200 procedures per year) and a marked increase in mortality.

In light of Delaware's small size and close proximity to major metropolitan referral centers, particularly in Philadelphia and Baltimore, it is seen as neither necessary nor desirable that every possible health care service be available within its borders. The introduction of a technology into the state should occur only after a careful evaluation of factors such as the following:

- Is the population to be served by the proposed technology large enough to assure a volume of patients sufficient for high quality services?

- What are the access problems associated with the continued use of out-of-state providers? How will these problems be remedied by the presence of the service in Delaware?

- What are the relative cost implications of providing the service in Delaware versus out-of-state?

The burden of proof falls on the applicant in terms of justifying the introduction of a new technology in Delaware. The mere fact that it is not available in the state is insufficient justification. On the other hand, the rigid exclusion of a technology from the state (regionalization for regionalization's sake) is also to be avoided and stances on a particular technology must be evaluated as circumstances change. In summary, technologies are to be introduced into the state only after a thorough assessment of the impact on cost, quality and access.

In conducting this assessment, the impact on cost, quality and access will be viewed from the following perspectives:

- Cost - By and large the Board is more concerned with the impact of a technology on overall health care costs than resultant charge levels which can reflect a variety of phenomena such as cost shifting, cross subsidization among services and pricing strategies aimed at increasing market share.

- Quality - Assessing the impact on quality can be difficult because measuring quality is often quite subjective. Nevertheless, the benefits of the technology will be examined (ideally patient outcomes information will be available) along with any "critical mass" thresholds which should be met to help assure proficiency. The assurances of outside licensing and accreditation requirements can be considered also.

- Access - An evaluation of the impact on access will focus not only on the proximity of the population to the technology in question (including a consideration of transportation resources) but on a number of other dimensions of access also. These include the availability of resources, the accommodation of clients (hours of operations, appointment systems, etc.), the affordability of the services to clients, and the acceptability of the provider and the services to clients.

While it is important to consider resources in other states which are available to serve the needs of Delawareans, it is equally important to recognize the presence of recognized regional providers which are located within Delaware.

The following generic questions, which have been taken largely from the Pennsylvania State Health Plan, may be used to assist in the analysis of CPR applications. Potential applicants should prepare their applications with these questions in mind.

GENERIC QUESTIONS

Efficacy

- What does the technology do? What are the benefits of the technology?
- Has efficacy been proven by clinical trials?
- Is the technology approved by the FDA? Is it still considered experimental?
- If the FDA has approved the technology, has it done so for all manufacturers?

Program Considerations

- What other programs should or must the provider have to support the equipment or service?
- What types of manpower (physicians, technologists, etc.) are needed by this technology?
- Are sufficient manpower resources available?

Cost

- What is the capital cost of the required equipment (if any)?
- What are the other capital (renovations, interest, and depreciation) and non-capital costs (new staff) directly related to the new technology?
- What other cost in other programs will be incurred?
- Is there any potential cost savings (e.g. reduced length of stay)?
- Is Medicare, Medicaid, Blue Cross or Blue Shield, or any private health insurer reimbursing for this procedure or equipment?
- What is the overall impact on community costs, not only for Delaware but the region, if applicable, considering operating costs, utilization and charges?

System Efficiency

- What medical diagnostic groups could benefit from the technology?
- What is the estimated number of procedures needed per 100,000 population?
- In how many facilities in the state should the new technology be available?
- What priorities (i.e., teaching, research, geography) should be considered in locating the equipment?
- How could the technology be shared on a regional basis?

Institutional Efficiency

- What is the maximum number of procedures that could be performed per day, week, and year?
- To what extent will the technology: supplement existing equipment or services? replace existing equipment/services? replace staff? increase the number of support staff?
- What is the effect of the technology on current hospital utilization (inpatient and outpatient)? For example, will it reduce inpatient hospital days?

Institutional Quality

- Are there any existing national or state or Joint Commission guidelines with respect to the use of the technology?
- Is there a minimum number of procedures that should be performed per day, week, or year to maintain staff expertise?

Obsolescence

- What is the estimated productive life of the equipment?
- What new improvements can be expected in the equipment? What time frame?
- What would the impact of these new improvements be on the current equipment?
- What other technologies could be expected to replace this technology? What would be their time frames?

FREESTANDING SURGERY CENTER NEED CRITERIA

(As adopted by the Delaware Health Resources Board on April 24, 2008)

The Freestanding Surgery Center Task Force was charged to develop Certificate of Public Review standards for freestanding ambulatory surgery centers. The Task Force reviewed the standards which were previously utilized by the Board as well as those from Georgia, Michigan and West Virginia. Additionally, the Task Force examined utilization statistics from a statewide representative sample of freestanding ambulatory surgery centers. The universe of freestanding ambulatory surgery centers includes facilities which are state licensed or Medicare certified or which provide ambulatory surgery as the primary business activity and operate as a separate and independent business.[1] In Delaware, endoscopy and pain management centers are not reviewable and were excluded from the examination. Finally, the Task Force looked at the national utilization data and the one from the state of Indiana. Based upon the review, the Task Force recommends the standards below to the Board for adoption.

Review Criteria for Free Standing Ambulatory Surgery Centers

Need Methodology

The need for a Free Standing Surgery Center (FSSC) shall be considered by evaluating the "projected need" and comparing the "projected need" to the "existing supply" of Rooms.

The development of a FSSC is encouraged when additional Room capacity is needed in a Service Area.

A. Definitions

Population: The number of people living in the Service Area where the proposed FSSC will be located. *Source = Delaware Population Consortium.*

Rooms: The total number of operating rooms and procedure rooms within the Service Area of the proposed FSSC. The total should include: 1.) 100% of the existing ambulatory surgery center operating rooms and procedure rooms, 2.) 65% of the hospital operating rooms and procedure rooms, and 3.) the operating rooms and procedure rooms which have received CPR approval but have not opened yet. *Sources =Delaware Healthcare Association (DHA), Office of Health*

[1] National Center for Health Statistics: http://www.cdc.gov/nchs/nsas.htm

Facilities (OHFLC) Licensing & Certification and the Delaware Health Care Commission/Delaware Health Resources Board.

Websites
Delaware Healthcare Association
=www.deha.org
Office of Health Facilities Licensing & Certification
=www.dhss.delaware.gov/dhss/dph/hsp/hflc.html
Delaware Health Care Commission/Delaware Health Resources Board
= http://dhss.delaware.gov/dhss/dhcc/hrb/dhrbhome.html

Service Area: The County where the ambulatory surgery services shall be provided.

Surgical Use Rate: The estimate is 104.2 visits per 1,000 population. Source: National Health Statistics Center, Ambulatory Surgery in the United States, 1996 report, updated to reflect NHSC estimates for 2006)

B. Calculations

See Exhibits.

C. Requirement for Existing Facilities to Obtain a Certificate of Public Review to Increase the Number of Operating Rooms

All existing providers of surgical services subject to Certificate of Public Review shall not increase the number of their operating rooms without first obtaining a Certificate of Public Review.

D. Special Considerations

The Delaware Health Resources Board recognizes that there are factors other than the mathematical formula (see Exhibits) to establish need. Therefore, the Delaware Health Resources Board will accept a detailed petition to consider these factors in making its decision.

E. Additional Requirements

1. An applicant shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Office of Health Facilities Licensing and Certification, Division of Public Health, Delaware Department of Health and Social Services.

2. An applicant shall foster an environment that assures access to services to individuals unable to pay regardless of the payment source or circumstances. The applicant shall:

    a. Provide evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis to all patients

including those covered by Medicare, Medicaid and other government sponsored plans, as well as managed care or traditional fee for service plans; and

b. Provide a written commitment that unreimbursed services for indigent and charity patients will comply with the requirements of the Charity Care provision of the Health Resources Board.

EXHIBIT 1

Based on Current Kent County Data

1. Calculation of # of Patients Needing Surgery

A	Surgical Use Rate	10.42%	see definition
B	Population (Kent County 2010 Projection)	157,404	see definition
C (AxB)	# of Patients Needing Surgery	16,401	

2. Calculation of the # of Surgical Visits Per Room Per Year

D	# of Surgeries per Hour	1	assumption
E	# of Hours per Day	8	assumption
F	# of Work Days per Year	250	assumption
G (DxExF)	# of Surgical Visits Per Room Per Year	2,000	

3. Calculation of the # of Surgical Visits that Would Justify Approving an Additional Room

G	# of Surgical Visits Per Room Per Year	2,000	from above
H	Utilization Percentage Needed to Approve New Rooms	70%	assumption
I (GxH)	# of Surgical Visits that Would Justify Approving an Additional Room	1,400	

4. Calculation of the # of Rooms Needed

C	# of Patients Needing Surgery	16,401	from above
I	# of Surgical Visits that Would Justify Approving an Additional Room	1,400	from above
J (C / I)	# of Rooms Needed	12	

5. Calculation of the # of Rooms Available

K	# of Licensed Rooms (Based on Kent County Actual as of 2/2008)	16	via OHFLC
L	# of Rooms Approved by DHRB that could be Licensed	4	
M (K+L)	# of Rooms Available	20	

6. **Calculation of Surplus (Deficit)**

M	# of Rooms Available	20	from above
J	# of Rooms Needed	12	from above
N (M-J)	Surplus (Deficit)	8	

EXHIBIT 2

Based on Current Sussex County Data

1. Calculation of # of Patients Needing Surgery

A	Surgical Use Rate	10.42%	see definition
B	Population (Sussex County 2010 Projection)	194,430	see definition
C (AxB)	# of Patients Needing Surgery	20,260	

2. Calculation of the # of Surgical Visits Per Room Per Year

D	# of Surgical Visits per Hour	1	assumption
E	# of Hours per Day	8	assumption
F	# of Work Days per Year	250	assumption
G (DxExF)	# of Surgical Visits Per Room Per Year	2,000	

3. Calculation of the # of Surgical Visits that Would Justify Approving an Additional Room

G	# of Surgical Visits Per Room Per Year	2,000	from above
H	Utilization Percentage Needed to Approve New Rooms	70%	assumption
I (GxH)	# of Surgical Visits that Would Justify Approving an Additional Room	1,400	

4. Calculation of the # of Rooms Needed

C	# of Patients Needing Surgery	2,260	from above
I	# of Surgical Visits that Would Justify Approving an Additional Room	1,400	from above
J (C / I)	# of Rooms Needed	14	

5. Calculation of the # of Rooms Available

K	# of Licensed Rooms (Based on Sussex County Actual as of 2/2008)	23	via OHFLC
L	# of Rooms Approved by DHRB that could be Licensed	3	
M (K+L)	# of Rooms Available	26	

6. Calculation of Surplus (Deficit)

M	# of Rooms Approved	26	from above
J	# of Rooms Needed	14	from above
N (M-J)	Surplus (Deficit)	12	

EXHIBIT 3

Based on Current New Castle County Data

1. Calculation of # of Patients Needing Surgery				
A	Surgical Use Rate		10.42%	see definition
B	Population (New Castle County 2010 Projection)		541,350	see definition
C (AxB)	# of Patients Needing Surgery		56,409	
2. Calculation of the # of Surgical Visits Per Room Per Year				
D	# of Surgical Visits per Hour		1	assumption
E	# of Hours per Day		8	assumption
F	# of Work Days per Year		250	assumption
G (DxExF)	# of Surgical Visits Per Room Per Year		2,000	
3. Calculation of the # of Surgical Visits that Would Justify Approving an Additional Room				
	# of Surgical Visits Per Room Per Year		2,000	from above
	Utilization Percentage Needed to Approve New Rooms		70%	assumption
I (GxH)	# of Surgical Visits that Would Justify Approving an Additional Room		1,400	
C Calculation of the # of Rooms Needed				
C	# of Patients Needing Surgery		56,409	from above
I	# of Surgical Visits that Would Justify Approving an Additional Room		1,400	from above
J (C / I)	# of Rooms Needed		40	
Calculation of the # of Rooms Available				
K	# of Licensed Rooms (Based on New Castle County Actual as of 2/2008)		84	via OHFLC
L	# of Rooms Approved by DHRB that could be Licensed		0	
M (K+L)	# of Rooms Available		84	
Calculation of Surplus (Deficit)				
M	# of Rooms Approved		84	from above
J	# of Rooms Needed		40	from above
(M-J)	Surplus (Deficit)		44	

CHARITY CARE POLICY

(Procedures for Implementation are included in accompanying Implementation Requirements which follow on page 36 of this document)

1. Goals

The goals of the charity care policy are to:

- Promote access to care for low income uninsured and underinsured Delawareans
- Level the playing field between not-for-profit hospitals and freestanding health care centers

II. Definitions

Charity Care: Charity care is defined as non-reimbursed charges for services to income-tested patients who are uninsured or underinsured.

Charity care may be determined prospectively or retrospectively. It does not include bad debt (uncollectible payments), Medicaid or Medicare payment shortfalls or contractual allowances with third-party payers. It may include patient out-of-pocket expenses for income-tested patients who are uninsured or underinsured. Charity care discounts may include the provision of free care or care provided in accordance with an income-based, sliding fee scale.

Level-the-playing field: As referenced in I. Goals above, means recognizing that not-for-profit, acute care hospitals use revenues generated from the provision of "profitable" services to offset the costs of providing "unprofitable" services that, nevertheless, are necessary and beneficial to society. A "profitable" service is a service for which a hospital is reimbursed an amount greater than the total cost of providing the care.

III. Requirements

As a condition of receiving a Certificate of Public Review, a freestanding health care center must develop a formal, written charity care plan and file a copy of it with the Delaware Health Care Commission/Delaware Health Resources Board at the time of application for a CPR approval. The Board may request that the center amend its plan if it is determined to be unsatisfactory.

The center must participate in the CHAP/VIPII provider network and/or other Board-approved charitable programs, and encourage physicians who are credentialed to use the center to participate also.

On an annual basis, the Board will determine the amount of charity care to be provided by centers.

IV. Patient Notifications

Freestanding health care centers must notify patients of their charity care plan and their application processes. Such notice shall include visually prominent multilingual postings. Centers shall also orally inform patients. Patients who apply must be informed about the status of their application and, if approved, the level of discount for which he or she qualifies.

V. Reporting Requirements

Freestanding health care centers approved for CPR must, annually submit to the Delaware Health Care Commission/Delaware Health Resources Board, a report from an independent, Delaware-licensed, certified public accountant that documents the amount of charity care they have provided during the year. Additionally, at the same time and for the same time period, the centers, must submit documentation of continued participation in the CHAP/VIPII provider network and/or other Board-approved charitable programs.

VI. Enforcement

The Delaware Health Resources Board shall collect information on the amount of charity care provided by centers that are obligated to provide such care. Failure to participate in the charity care procedures set forth by the Board shall result in the Board making a report to the Delaware Health and Social Services designee responsible for compliance with applicable state laws and regulations, in accordance §9312 (3)Title 16, Delaware Code. The Board will designate all fiscal remedies for non-compliance, including pre-approved health care centers or services to which fiscal remedies for non-compliance will be directed.

This policy may be amended by Delaware Health Resources Board as it deems appropriate and/or necessary.

CHARITY CARE POLICY: IMPLEMENTATION REQUIREMENTS

This document is to be read in conjunction with the Charity Care Policy that appears in this Delaware Health Resources Management Plan.

I. Goals

As stated in the Charity Care Policy: "The goals of the charity care policy are to:

- Promote access to care for low income uninsured and underinsured Delawareans
- Level the playing field between not-for-profit hospitals and freestanding health care centers

II. Definitions

Charity Care

As stated in the Charity Care Policy: "Charity care is defined as non-reimbursed charges for services to income-tested patients who are uninsured or underinsured. Charity care may be determined prospectively or retrospectively. It may include out-of pocket expenses for income-tested patients who are uninsured or underinsured. Charity care discounts may include the provision of free care or care provided in accordance with an income-based, sliding fee scale."

In addition to directly providing medical services at reduced or no cost to the medically indigent, facilities can meet their charity care requirement by facilitating the development and operation of primary medical services to indigent persons. Examples of what this could include are providing a new service such as a free clinic or making a donation to a pre-approved safety net provider (see Appendix D for a list of pre-approved providers) whose mission is to care for the medically indigent.

Facilities can also count toward their charity care contribution enabling services that make it possible for medically indigent patients to receive services at their facility whom otherwise would not be able to do so. Examples include making arrangements for free or reduced cost transportation to and from the facility, translation services for non-English speaking medically indigent patients, communication services for deaf or hard-of-hearing patients, or home care following a surgical procedure for medically indigent persons.

Additionally, facilities can arrange for and count toward their charity care:

- forgone physician fees for procedures performed at the facility for the medically indigent, and/or
- no cost/reduced cost laboratory services for their medically indigent patients.

One way this could be achieved is for the facility to cover the cost of these services for the medically indigent patients.

Patients eligible for charity care are those individuals whose individual/family income is less than or equal to 350% percent of the Federal Poverty Level (FPL), as published in the Federal Register for the year in question, and who are uninsured or underinsured (i.e., overall medical expenses and/or health plan deductible equal to or exceeding 5 percent of income[1]). The intent is to encourage the provision of charity care to patients whose medical expenses would otherwise create a financial hardship.

Note: See Appendix A for Federal Poverty Guidelines.

Facilities subject to the charity care requirement are encouraged to provide services to all patients without regard to an individual's ability to pay. A minimum of the average amount of charity care provided by Delaware acute care hospitals in the previous year must be provided as free or reduced charge services to persons at or below 350% percent of the Federal Poverty Level. This percentage will be updated and published by the Delaware Health Care Commission on behalf of the Delaware Health Resources Board.

A minimum of the average percentage of total gross patient charges (also known as gross patient revenue) that is provided in the form of charity care by Delaware hospitals, as reported by the Delaware Healthcare Association, must be provided in the form of charity care by Free Standing Surgery Centers.

Note: See Appendix B for current Required Charity Care Write-Off Amount

Charity care does not include payment reductions resulting from contractual adjustments, uncollectibles, or other non-charity sliding scale discounts/allowances. It also does not include payments and/or uncollectibles from charity care patients who are assessed a sliding scale fee for service. The remaining amount forgiven after these payments is considered charity care.

The charity care condition remains in effect over the operational life of the facility authorized by the Delaware Certificate of Public Review (CPR), unless otherwise notified by the Delaware Health Care Commission on behalf of the Delaware Health Resources Board.

Level-the -playing field:

As stated in the charity care policy, and as referenced above, "level the playing field" means: "recognizing that not-for-profit, acute care hospitals use revenues generated from the provision of "profitable" services to offset the costs of providing "unprofitable" services that, nevertheless, are necessary and beneficial to society. A "profitable" service is a service for which a hospital is reimbursed an amount greater than the total cost of providing the care."

An example of "profitable" service might include a lower-risk, uncomplicated surgical procedure. Examples of "unprofitable" services might include a high-risk obstetric delivery, a complex psychiatric service or emergency department care,

[1] Schoen, Cathy; Doty, Michelle Doty; Collins, Sara; and Homgren, Alyssa; ***Insured But Not Protected: How Many Adults Are Underinsured?*** Health Affairs, June 14, 2005.

for which a hospital is reimbursed less than the cost of providing the care. Uncompensated care provided to an uninsured or underinsured patient is another example of the provision of unprofitable care.

III. Requirements:
As stated in the Charity Care Policy: "As a condition of receiving a Certificate of Public Review, a freestanding health care center must develop a formal, written charity care plan and file a copy of it with the Delaware Health Care Commission/Delaware Health Resources Board at the time of application for a CPR approval. The Board may request that the center amend its plan if it is determined to be unsatisfactory. The center must participate in the Community Healthcare Access Program/Volunteer Initiative Program (CHAP/VIPII) provider network and/or other Board-approved charitable programs, and encourage physicians who are credentialed to use the center to participate also. On an annual basis, the Board will determine the amount of charity care to be provided by centers."

Specifically, at the facility, if a patient's eligibility for charity care has not been pre-determined, for example through the CHAP and/or VIPII eligibility and enrollment process, the facility must begin the process of determining eligibility during the process of scheduling the patient for services or as soon as the patient requests financial assistance with their medical bills.

See Appendix C for a description and contact information for CHAP/VIPII

A facility may use a sliding fee scale to determine the fees to be charged patients who are eligible for charity care services. If the facility uses a sliding fee scale and changes it, the new sliding fee scale must be submitted to the Delaware Health Care Commission/Delaware Health Resources Board. Free-standing facilities subject to the charity care provision are encouraged to accept all patients for medically necessary procedures regardless of ability to pay and strive to maintain a minimum Medicaid utilization level of 10 percent of gross revenue.

Facilities' charity care plans shall include, but not necessarily be limited to:

- Explanations about the availability of charity care
- Time period and procedures for eligibility
- Applications and forms needed
- Facility location and hours during which information may be obtained by the general public

IV. Patient Notifications:
As stated in the charity care policy: "Freestanding health care centers must notify patients of their charity care plan and their application processes. Such notice

shall include visually prominent multilingual postings. Centers shall also orally inform patients. Patients who apply must be informed about the status of their application and, if approved, the level of discount for which he or she qualifies."

Specifically, patient notification shall be published in at least English and Spanish. Postings of the charity care plan must be made in a location that is highly visible to patients, such as the patient reception area and in patient correspondence.

V. Reporting Requirements:

As stated in the charity care policy: "Freestanding health care centers approved for CPR must, annually submit to the Delaware Health Care Commission/Delaware Health Resources Board, a report from an independent, Delaware-licensed, certified public accountant that documents the amount of charity care they have provided during the year. Additionally, at the same time and for the same time period, the centers, must submit documentation of continued participation in the CHAP/VIPII provider network and/or other Board-approved charitable programs. "

Specifically, free-standing health care centers approved for CPR must, in accordance with the provisions of the federal Health Insurance Portability and Accountability Act and state law, maintain a charity care log that documents the services provided. The log must be certified as accurate by the facility administrator. The log shall include at a minimum:

- The date of service provided
- The patient's age
- ZIP code, city and county of patient's residence
- Total charges for the services provided
- Any amount charged to the patient
- Any associated physician and medical service fees (if known)

The facility shall submit a copy of the log and a summary data sheet within 180 days of the beginning of each calendar year for the previous calendar year to the Delaware Health Care Commission/Delaware Health Resources Board.

The summary data sheet will include:

- Date that the facility became operational
- Annual amount of total patient gross revenue collected by the facility for the fiscal year being reported
- Dollar amount and percentage of total gross patient revenue forgone to charity care
- Dollar amount written off as charity for "other", with detailed description (e.g. provided a free service such as a free clinic, facility-covered transportation costs for the patient, contracted physician fee write off, etc.)
- Dollar amount and percentage of total gross revenue written off as bad debt
- Dollar amount of Medicaid gross revenue as a percentage of total gross patient revenue

The form for submitting the summary information will be provided by the Delaware Health Care Commission/Delaware Health Resources Board to conditioned facilities.

In a separate letter, documentation of enrollment in the VIPII program (please see Appendix C of this document for information about VIPII), or other Board-approved charitable program(s) must be reported by the conditioned facility to the Delaware Health Care Commission/Delaware Health Resources Board every year at the same time that the charity care log and data summary sheet is submitted.

The Delaware Health Care Commission/Delaware Health Resources Board may take any necessary actions to verify the accuracy of information submitted.

VI. Enforcement:

As stated in the charity care policy, the Delaware Health Resources Board shall collect information on the amount of charity care provided by centers that are obligated to provide such care. Failure to participate in the charity care procedures set forth by the Board shall result in the Board making a report to the Delaware Health and Social Services designee responsible for compliance with applicable state laws and regulations, in accordance §9312 (3)Title 16, Delaware Code. The Board will designate all fiscal remedies for non-compliance, including pre-approved health care centers or services to which fiscal remedies for non-compliance will be directed.

The specific procedures for enforcement are as follows. If the charity care condition is not met:

1. At the end of the first year of providing services to patients:
    - The facility shall provide a written explanation for why the charity care requirement was not met.
    - The facility shall also appear before the Board and provide an oral presentation(s) on why the charity care requirement was not met
    - The facility shall submit a proposed course of correction for approval by the Board.

Should the Board determine that the proposed course of correction is not acceptable, the Board may require a monetary assessment equal to the amount of charity care that was to be provided during year one or the difference between what should have been provided and what was actually provided. The facility will submit this amount to a pre-qualified safety net provider.

See appendix D for the list of pre-qualified providers.

2. Subsequent years:

   The facility shall submit a monetary assessment to a pre-qualified safety net provider (Appendix B of this document for the list of pre-qualified providers) equal to the amount of charity care that was to be provided during that fiscal year, or the difference between what should have been provided and what was actually provided. A copy of the check shall be provided to the Delaware Health Care Commission/Delaware Health Resources Board (phone: 302-739-2730). Please call to confirm mailing and fax address.

Appendix A

Federal Poverty Guidelines – 2009

2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
Source: Federal Register, Volume 74, Number 14, January 23, 2009, pp. 4199-4201) http://aspe.hhs.gov/poverty/

Persons in family	FPL guidelines (100% FPL)
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add $3,740 for each additional person.

(Bureau Staff Note: For 2009, 350% FPL is $71,565 for a family of four.)

Median Family Income
Source: U.S. Census Bureau
http://www.census.gov/hhes/www/income/statemedfaminc.html

Delaware's three-year average (2005-2007) median household income: $54,462

Median family income by the number of earners in family:

- Two earners: $85,987
- One earner: $$46,414

Appendix B

Required Charity Care Write-Off Amount

On average, Delaware hospitals provide 2% of total gross patient revenue in the form of charity, according to the Delaware Healthcare Association. This is the amount that is required by the Delaware Health Resources Board to be provided in 2008 by Free Standing Surgery Centers.

The write off amount is to be compared to the total gross patient revenue reported by the facility for the previous year. For example, the facility must show that the amount of charity care provided in 2008 was at least 2% of the total gross patient revenue for the facility in 2007.

Appendix C

CHAP/VIPII Programs for the Uninsured

The Community Health Care Access Program (CHAP) provides access to primary care doctors, medical specialists, and help with access to other health resources including prescription programs, laboratory and radiology services. Medical services are provided in the community through Community-based Health Care Centers and private doctors who participate in the Medical Society of Delaware's **Voluntary Initiative Program II (VIPII)**. VIPII is a network of private physicians statewide who accept CHAP patients into their practices and serve as their health home or provide medical subspecialty services. CHAP recipients receive discounted medical services based upon their income. In brief, the CHAP program gets patients the medical attention they need at an affordable cost. To be eligible for CHAP, an individual must be a resident of Delaware, uninsured, ineligible for state medical assistance programs, and meet financial eligibility guidelines (200% FPL).

To find out more about these programs or eligibility, please call **2-1-1**.

Appendix D

Pre-Qualified Safety Net Providers

New Castle County
Henrietta Johnson Medical Center
Westside Family Healthcare
Claymont Family Health Services

Kent County
Kent Community Health Center/Delmarva Rural Ministries
The Hope Clinic

Sussex County
La Red Health Center