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

STANDARDS FOR INSTITUTIONS

The Division of Public Health establishes and maintains health standards for private or public institutions (exclusive of Christian Science Sanatoria) in which recipients may receive care or service.

The Division of Public Health also establishes standards other than those related to health for such institutions. These standards are set in accordance with Section 1864 (a) of the Social Security Act, Section 1902 (a) of the Social Security Act and Delaware Code Title XVI (various.)

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METHODS FOR CONTROL OF UTILIZATION OF
INTERMEDIATE CARE FACILITY SERVICES

The Delaware Medial Services Unit has a team if R.N.'s, social workers, and physician consultants that comprise and Independent Professional Review Team. The reviews conducted by this team serve as one utilization review per year in accordance with 42 CFR 456.431 (b)(2)(i) & (ii).

The Medical Services Unit has contracted with the Division of Public Health to conduct the other semi-annual utilization review in accordance with 42 CFR 456.431 (a).

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COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND
STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

The Division of Economic Services has cooperative agreements with the Division of Public Health (which is also the State's Title V grantee), the Division of Mental Health and the Division of Vocational Rehabilitation in accordance with the requirements of 42 CFR 431.615.

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LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   A client who has resided in a medical institution for at least sixty (60) consecutive days is presumed not to be reasonably expected to be discharged and returned home. Transfers from one medical institution to another do not interrupt the sixty (60) day period. Accordingly, Delaware Health & Social Services (DHSS) will exercise its right to file a lien on the real property.

   A pamphlet, which describes the policy, is given to applicants. Further, the policy is reviewed with the client and/or representative during the Medicaid application process. The policy defines what a lien is, explains the lien will not lead to loss of ownership as a result, and advises the client or his/her representative of their right to request an appeal through the fair hearing process.

2. The following criteria are used for establishing that permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR§433.36(f):

   Delaware Health & Social Services (DHSS) shall not seek recovery in the case of a lien on an individual's home when there is a son or daughter over the age of twenty-one (21) lawfully residing in the home of the client whom:

   a) has resided there for a period of at least two (2) years immediately prior to the date of the client's admission to a long-term care service;

   b) has lawfully resided there on a continuous basis since that time; and

   c) can establish to the Department's satisfaction that he or she provided the care and assistance that permitted the recipient to reside in the home rather than in a long-term care facility.

   The son or daughter may demonstrate having rendered care or assistance that resulted in a delay in the need for institutionalized care by means of a written statement from an institutionalized individual's attending medical attending physician or another person or persons who have personal knowledge of the living circumstances of the individual. The written statement must indicate that the individual was able to remain in his or her home because of the care provided by the child. A written statement only from the child will not satisfy this requirement.

   NOTE: DHSS can seek recovery from other assets in the estate.

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3. The State defines the terms below as follows:

- ***Estate*** ***means all real and personal property and other assets included within an individual's estate as provided in the State probate law.***
- ***Individual's home*** ***means his or her principal place of residence.***
- ***Equity interest in the home*** ***means a formal legal interest such as mortgage or loan.***
- ***Residing in the home for at least one (1) or two (2) years on a continuous basis*** ***means using the home as the principal place of residence.***
- ***Discharge from the medical institution and return home*** ***means the release of a person from a long-term care facility for the purpose of returning to the home for permanent residence or discontinuance of home and community-based services. Individuals must meet the institutional criteria in order to be eligible for the home and community-based waiver services (42CFR435.217). Therefore, these services are considered "institutional".***
- ***Lawfully residing*** ***means residing in the home with the permission of the owner or, if under guardianship, the owner's legal guardian.***

4. The State defines undue hardship as follows:

In cases of undue hardship, recovery may be waived for the period of the hardship.
Undue hardship exists for certain individuals who have resided in the home of the DHSS long-term care recipient on a continuous basis for a period of at least two (2) years (twenty-four consecutive months) immediately prior to the date of the DHSS long-term care recipient's admission to DHSS long-term care services.

Individuals eligible for recovery waiver are limited to children, grandchildren, parents, or siblings of the DHSS long-term care recipient who meet one of the following conditions:

Receive any Federal or State funded assistance for living expenses (examples: SSI, AFDC, VA Aid and Attendance) and have no other home to which they can return.

OR

Have total family income less than or equal to 200% of the current monthly Federal Poverty Limit, and have total family resources that can be converted to cash less than or equal to $3,000, including any real property that they own.

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OR

DHSS will also not recover if the real property that is held in ownership with children, grandchildren, siblings or parents constitutes a business that contributes to the livelihood of that other individual or his/her dependents or heirs.

In cases of undue hardship, liens against the real property of DHSS long-term care recipients shall be filed, but a moratorium established on the lien. The moratorium on imposing the lien on the home will exist as long as the hardship condition continues to be met and as long as the above-described individuals reside in the DHSS long-term care recipient's home on a continuous basis.

NOTE: The waiver for recovery will exist as long as one of the above conditions continues to be met and as long as the above-described individuals reside in the DHSS long-term care recipient's home on a continuous basis.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause undue hardship, and when recovery is not cost effective.

Standards: Same as number 4 above.

Procedures: If a hardship condition is requested and verified when the referral for estate recovery is received, it is tracked for eight (8) months. If, at the end of eight (8) months, the hardship condition still applies, the recovery case is closed because Delaware probate law requires that claims against estates be filed within eight (8) months of the date of death.

Not Cost Effective: Criteria for determining cost effectiveness are set forth below in number 6.

6. The State defines when adjustment or recovery is not cost effective. The State defines cost effectiveness as follows (include methodology/thresholds used to determine cost effectiveness.

If there are no resources for burial and the total assets in the estate are less than $5,000 then, it is not considered cost effective to pursue because the State's probate law requires that funeral expenses be paid first.

If there are resources for burial in the amount of $5,000 then it is considered cost effective to pursue if there are assets in the estate.

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LIENS AND ADJUSTMENTS OR RECOVERIES CONTINUED

7. The State uses the following collection procedures (include specific elements contained in the advance action notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

Delaware Health and Social Services (DHSS) notifies the client in advance by distributing a pamphlet to the client, guardian, and/or responsible party, outlining estate recovery procedures, at the time of application to all applicants for approved Medicaid State plan services, including long-term care services.

All persons receiving or applying for approved Medicaid Slate plan services, including long-term care services, are advised in writing about the estate recovery policy of DHSS at the time of application and redetermination, via the ERL1.DOC form titled, "Recovery and Lien Policy". This form outlines the following:

- Explanation of estate recovery, including citations of the federal and state authority;
- Defines long-term care;
- Describes the circumstances under which DHSS will file a claim;
- Describes the circumstances under which DHSS will file a lien;
- Defines what a lien is explains that the lien will not lead to loss of ownership;
- Describes what constitutes undue hardship. Exclusion and hardship waiver conditions are listed on page 2 of this form titled, "Request for Exclusion or Hardship Waiver";

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LIENS AND ADJUSTMENTS OR RECOVERIES CONTINUED

Specifies which Medicaid payments DHSS will seek to recover: and,

Notifies the applicant, guardian, and/or responsible party of appeal procedures, specifically stating, "If you are dissatisfied with any decision made by the Division of Medicaid and Medical Assistance (DMMA), you have the right to request an appeal of the decision by requesting a fair hearing. You must submit a written request to the local DHSS office within 90 days of the action".

DHSS exempts from estate recovery all Medicare Savings Program cost sharing benefits with dates of service on or after January 1, 2010 for qualified dual eligibles age 55 and over, but otherwise DHSS shall seek estate recovery after the client's death of the maximum recoverable amount to be defined as the total of funds disbursed or incurred by DHSS (including Federal matching dollars) during the time an individual, age 55 and over, receives covered Medicaid services paid for by DHSS including the total capitation payments for the period the beneficiary was enrolled in the managed care organization (MCO). When the beneficiary enrolls in the MCO, the State provides a separate notice to the beneficiary, explaining premium payments made to the MCO are included in the claim against the estate.

Collections efforts will include written notification to the executor, guardian, and/or responsible party of the client's long-term care balance owed via a claim summary report. If a lien was placed on the client's property upon entry to the long-term care institution, DHSS will place a recovery claim against the proceeds from the sale of the property. DHSS will also pursue obtaining any residual funds remaining in a trust to offset any balance owed DHSS. Upon request, DHSS will work with heirs of the estate who voluntarily wish to satisfy the recovery claim on a case-by-case basis offering mutually agreed upon payment schedules if necessary. Additionally, when the maximum recoverable amount cannot be collected DHSS may agree to accept partial recoveries.

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STATE/TERRITORY: **DELAWARE**

A. The following charges are imposed in the categorically needy for services other than those under section 1905 (a) (1) through (5) and (7) of the ACT:

Service	Type of Charge			Amount and Basis for Determination
	Deductible	Coinsurance	Co-Payment	
Pharmacy	-0-	-0-	x	This co-payments is effective January 10, 2005 and is based upon the cost of the drug as follows:

Medicaid Payment for the drug	Co-Payment
$10.00 or less	$.50
$10.01 to $25.00	$1.00
$25.01 to 50.00	$2.00
$50.01 to more	$3.00

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B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Provides are responsible for collecting the cost sharing from individuals

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Pharmacy Services Co-payment

The Pharmacy (Pharmacist) Provider will be advised via the Point-of-Sale System regarding the client's liability for the drug co-payment and the amount of the co-payment. When a client advises a pharmacy of an in ability to pay the applicable co-payment amount at the time the prescription is filled, the pharmacy cannot refuse to fill the prescription and must dispense the drug as prescribed.

The client will remain liable for reimbursement for the co-payment amount and will be responsible for paying the pharmacy when financially able. Medicaid will not pay the co-payment amount to the pharmacy where a client declares an in ability to pay. Provider payment will continue to be the sum which is the Medicaid fee minus the applicable client co-payment amount.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

Exclusions from cost sharing requirements are programed into the Medicaid Management Information System and the Point-of-Sale (POS) System.

Providers are informed about applicable service and amount and, the prohibition of service denial if client is unable to meet the co-pay amount by the following methods: (1) provider manuals, which are distributed to all providers; (2) DMAP website; and (3) provider newsletters.

Co-payment requirements are set forth in provider manuals, which are distributed to all providers. The billing instructions are updated and transmitted to providers via the Provider Newsletter. These instructions are incorporated in the billing instruction section of the provider manuals, which are given to all providers.

E. Cumulative maximums on charges: See descriptions below:

☒ **For Pharmacy Services Co-payment,** cumulative maximums have been established as described below:

$15.00 cumulative monthly maximum co-payments amount aggregated for pharmacy services. Once a client has met the individual monthly maximum co-payment for his or her prescriptions, the Point-of-Sale (POS) System will **NOT** indicate a co-payment is due. Medicaid will keep track of the cumulative number of prescriptions for a client with co-payments. Any prescriptions dispensed after the cumulative maximum monthly co-payment amount is met are not subject to a co-payment. Reversal of a previously filled prescription with a co-payment will require a refund of the co-payment to the individual and will cause the next prescription filled for that client to be adjusted with a co-payment.

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STATE/TERRITORY: N/A **DELAWARE**

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
N/A for Delaware				

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B. The method used to collect coat sharing charges for medically needy individuals:

☐ Providers are responsible for collecting the coat sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the coat sharing from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified is identified to provider, is described below:

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D. The Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximum.

☐ Cumulative maximums have been established as described below.

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Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902 (a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

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STATE/TERRITORY: N/A DELAWARE

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

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OPTIONAL SLIDING SCALE PREMIUMS IMPOSED ON
QUALIFIED DISABLED AND WORKING INDIVIDUALS

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

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STATE/TERRITORY: N/A DELAWARE

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

☒ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 (A)

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☐ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example - 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid 0MB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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Payment Adjustment for Provider Preventable Conditions

With the implementation of the HIPAA 5010 version of the 837 institutional claim, inpatient hospital claims that meet the criteria for an outlier payment AND that contain either of the following data elements on the claim will be suspended for manual review by Delaware Medicaid:

1) A Present on Admission indicator of "N", "U" or"1"

AND

A Medicare-defined Hospital Acquired Condition procedure or diagnosis code, except for deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients.

2) A diagnosis code of E8765, E8766 or E8767

For general acute care hospitals, if the portion of payment to the hospital directly related to treatment for and related to the Hospital Acquired Condition can be isolated, the payment for the outlier will be reduced by that amount and the hospital discharge payment and any remaining payable outlier amount will be paid on the claim. The discharge payment will not be reduced, as this part of the hospital payment would not have been increased as a result of the PPC. For hospitals that are paid a per diem rate, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on the average length of stay (ALOS) for the specific type of hospital from claims paid in the prior state fiscal year.

In compliance with 42 CFR 447.26(c), Delaware Medicaid provides:

1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

2) That reductions in provider payment may be limited to the extent that the following apply:

   i. The identified provider-preventable conditions would otherwise result in an increase in payment.
   ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

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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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
INPATIENT HOSPITAL CARE (Continued)

Rate Setting Method - Capital Payment Per Discharge

For the capital payment per discharge, a hospital-specific prospective rate was calculated *for* each accommodation type based on a blended percentage of total costs for each hospital represented by capital. A hospital-specific capital percentage was calculated by dividing total allowable capital costs for the hospital by total allowable costs for the facility as reported on each facility's FY92 cost report. A Statewide capital percentage was calculated by dividing total allowable capital costs for all Delaware hospitals by total allowable costs for all hospitals as reported on the cost report. The blended percentage is calculated by taking 75 percent of the hospital-specific capital percentage and 25 percent of the Statewide capital percentage. This blended percentage is then applied *to* the hospital operating rate per discharge *to* obtain the hospital capital per discharge rate.

Rate Setting Method - Medical Education Payment Per Discharge

For the medical education payment per discharge, a hospital-specific prospective rate was calculated for each accommodation type based on the percentage of total costs for each hospital represented by medical education costs. A hospital-specific medical education percentage was calculated by dividing total medical education allowable costs for the hospital by allowable total costs for the facility as reported on each facility's FY92 cost report. This hospital-specific percentage is then applied to the hospital operating rate per discharge to obtain the hospital medical education per discharge rate.

Rate Setting Method - Development of Implementation Year Operating Rates, Updates and Rebasing

The new inpatient rates will be implemented effective State FY95. The hospital-specific operating payments per discharge have been established for the implementation year by inflating the hospital-specific base year costs using the TEFRA target rate of increase limits published by HCFA. Base year costs were inflated from the midpoint of each hospitals' base year to the midpoint in State fiscal year 1995.

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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.

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Transplants - Transplant cases will be treated as outliers and, when appropriate, will be subject to the outlier payment policy. Organ acquisition costs will not reimbursed separately, but will be included in the per discharge rate.

Transfers/readmission - There will be no distinct payment policy for transfers/ readmissions between hospitals. These cases will be paid on a discharge basis. The PRO will conduct a periodic review to monitor these types of cases and determine that discharges are appropriate.

Split bill - For in-State cases and Out-of-State hospitals receiving per diem payment that span FY94 and FY95, the cost associated with the days in FY94 will be reimbursed using the current methodology. The full per-discharge rate will be paid for the days of care in FY95. Out of State hospitals who already use DRGs or a per discharge methodology will be paid the per discharge rate for all discharges on or after July 1, 1994.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
INPATIENT HOSPITAL CARE

A.I. DUPONT INSTITUTE OF THE NEMOURS FOUNDATION

Reimbursement Principle

Effective for discharges on or after January 1, 1995 the Medicaid Program will reimburse A.I. duPont Institute on the basis of prospective per discharge rates. Costs determined for A.I. duPont are hospital-specific but otherwise determined using the same methodology as the other acute care hospitals.

A.I. duPont per discharge rate will be discounted by the Institute through agreement with the Medicaid agency, not to exceed the rate established for comparable care in Delaware's other large teaching hospital. Rebasing and indexing of A.I. duPont's costs will be done on the same schedule as the other in-State acute care hospitals but specific to their fiscal year.

OUT-OF-STATE HOSPITALS

The operating, capital and medical education rates for acute care hospitals located outside of Delaware will be paid at the lowest Delaware rate for the hospital category to which they are assigned. Three categories of Delaware hospitals have been identified: urban, rural and major teaching. Out-of-State teaching hospitals are defined as those facilities which are members of the Council of Teaching Hospitals. Out-of-State urban hospitals are defined as non-teaching hospitals located in a metropolitan statistical area (MSA) as identified by the U.S. Bureau of Census. Out-of-State rural hospitals are defined as non-teaching hospitals located outside a metropolitan statistical area "MSA" as defined by the U.S. Bureau of Census. Out-of-State specialty/rehab hospitals will be paid at the Medicaid rate established by the State in which they are located

HOSPITALS WITH NEW PROGRAMS/SERVICES

For hospitals that begin a new medical education program for which there is no historical cost or claims data, the medical education payment will be paid at the average percentage for the Delaware teaching hospital category to which they are assigned. There are two categories of Delaware hospitals with regard to teaching: major teaching hospitals are defined as those facilities which are members of the Council of Teaching Hospitals. Minor teaching hospitals are all other hospitals in the state with a medical education program recognized by the Delaware Medicaid program.

Hospitals with other categories of new services can appeal their reimbursement rates using the appeals process.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL CARE

DISPROPORTIONATE SHARE HOSPITAL

Disproportionate Share Hospital (DSH) Payments

Delaware hospitals participating in the Delaware Medical Assistance (Medicaid) program that serve a disproportionate share of Medicaid and low income patients may be eligible for reimbursement from the Delaware Hospital DSH Fund. DHSS, DMMA has established criteria regarding the hospital qualifications and the maximum amount of reimbursement for hospitals that apply. For purposes of the DSH program, hospitals that have multiple geographic locations providing inpatient services will be treated as a single hospital when the hospital submits a consolidated Medicare cost report for its locations.

DSH Definitions

Note: The terms "costs", "charges" and "revenue/payment", as defined below, do not include the costs, charges and revenue/payment related to serving inmates of public institutions for which Medicaid funds are not available.

- Delaware Hospital DSH Fund - the total annual amount of funds available for distribution to DSH qualified hospitals. The amount is computed each year by the Medicaid agency based on the availability of state matching funds, the FMAP up to the maximum of Delaware's annual Federal DSH allotment.

- Hospital Specific DSH Limit - the maximum annual DSH payment amount a hospital can receive in accordance with section 42 CFR 447.299 (c)(16).

- Low Income Utilization Rate (per section 1923 (b) (3) of the Social Security Act) - In general, for an annual period, the Low Income Utilization Rate is the sum of the percentages computed by dividing:
    - Medicaid payments for inpatient and outpatient care by total hospital inpatient and outpatient payments received from all sources, plus
    - Inpatient charity care charges by total inpatient charges

- Medicaid Inpatient Utilization Rate (per section 1923 (b)(2) of the Social Security Act) - In general, for an annual period, the Medicaid Inpatient Utilization Rate is the percentage computed by dividing inpatient days attributable to patients who were eligible for Medicaid by total inpatient hospital bed days.

- Revenue - as used in connection with the DSH program means payments received from any source.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
INPATIENT HOSPITAL CARE

Disproportionate Share Hospital (DSH) Payments (cont'd)

- Uncompensated Care - as used in connection with the DSH program means the sum of the differences between:
  - The annual COST of inpatient and outpatient services to Medicaid eligible patients minus the inpatient and outpatient REVENUE (payments) received for Medicaid eligible patients (including both fee-for-service payments and payments made by Medicaid managed care organizations); plus
  - The annual COST of inpatient and outpatient hospital services provided to uninsured patients (excluding the cost of providing physician services to the uninsured) minus any payments received from or on behalf of the uninsured (including any Federal section 1011 payments for eligible aliens)
- Uninsured - as used in connection with the DSH program means a person who has no source of third party coverage (creditable coverage as defined in Federal regulations at 45 CFR 144 and 146). However, if adopted in final form, the term uninsured shall be defined in accordance with 42 CFR 447. 295

(a) Minimum Criteria:

No hospital shall receive disproportionate share hospital payments unless it meets the criteria in this section (a) and other criteria as specified in sections (b) or (c) or (d):

1) The hospital has a Medicaid Inpatient Utilization rate of at least 1% , and
2) The hospital has at least two obstetricians (or in the case of a rural hospital, two physicians) with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to Medicaid as per section 1923(d)(1) and (2) of the Social Security Act. This requirement does not apply to a hospital which did not offer non-emergency obstetric services to the general population as of December 21, 1987 or to a hospital that predominantly serves individuals under 18 years of age, and
3) The hospital's inpatient facility is physically located within the geographic boundaries of the State of Delaware, and
4) The hospital must agree to comply and cooperate with the DSH audit requirements, and
5) The hospital must submit a timely application with accurate data in accordance with section (f) below unless a waiver is granted by DMMA.

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Disproportionate Share Hospital (DSH) Payments (cont'd)

Hospitals that meet the criteria in this section (a) must also meet the criteria identified in either section (b) or (c) or (d) below in order to qualify for the Delaware DSH program.

(b) Additional Federal Criteria

If a hospital meets the criteria specified in section (a) above, the following subparagraphs 1 and 2 describe additional criteria that a hospital must meet to qualify as a disproportionate share hospital unless the hospital qualifies under sections (c) or (d):

1. The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State; OR

2. The hospital's low income utilization rate exceeds 25%.

(c) Delaware-Specific DSH Criteria for Acute Care General Hospitals

If a hospital meets the criteria specified in section (a) above, a hospital may qualify to receive disproportionate share hospital payments under this section if it meets all of the following criteria:

1) It is a not-for-profit hospital and is categorized under Delaware Medicaid criteria as an acute care general hospital and is not categorized as an Institution for Mental Diseases (IMO), and

2) The hospital has an inpatient facility located within an incorporated city in Delaware with a population greater than 50,000 and provides obstetric services at that facility to the general population including both fee-for-service and managed care Medicaid/CHIP recipients, and

3) During the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment, the hospital has been an enrolled provider with all participating Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for all inpatient and outpatient services offered by the hospital, and

4) The hospital's low income utilization rate exceeds 15%.

(d) Delaware Specific DSH Criteria for Psychiatric Hospitals (Institutions of Mental Disease - IMO):

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Disproportionate Share Hospital (DSH) Payments (cont'd)

If a hospital meets the criteria specified in section (a) above, a psychiatric hospital (IMD) may qualify as a disproportionate share hospital under this section if it meets all of the following criteria:

1) It must be a public psychiatric hospital (owned or operated by an agency of Delaware State government), and

2) It must serve a disproportionate share of low-income patients. For the purpose of this section (d), the term "disproportionate share" shall be defined as follows: sixty percent (60%) or more of the service revenue is attributable to a combination of the following:

- Public funds
- Bad debts
- Free care

(e) Payments to DSH Qualified Hospitals Under Delaware's Disproportionate Share Program:

1) DSH Payment Limits - All Delaware DSH Qualified Hospitals

A) The state share of payments made to all DSH qualified hospitals cannot exceed the State's maximum annual Delaware Hospital DSH Fund.

Per section 1923(f)(2) of the Social Security Act, an annual maximum Federal DSH allotment is computed for each state each federal fiscal year. Federal DSH funds can only be spent up to the corresponding amount of state matching funds that are available. The amount of federal DSH funds, the amount of state matching funds and the Medicaid federal/state match rate (FMAP) could change every year. Therefore, each year, the exact amount of the Delaware Hospital DSH Fund cannot be known in advance and will be computed by DMMA each year.

B) The amount of an annual DSH payment to an individual hospital must be the lesser of:

i) the Hospital-Specific DSH limit; or

ii) the amount determined in accordance with sections (e) (2), (e) (3) and (e) (4) below, or

iii) the amount determined in accordance with section (e) (1) (C) below.

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Disproportionate Share Hospital (DSH) Payments (cont'd)

C) In the event that the State's annual Delaware Hospital DSH Fund amount is not sufficient to make all of the payments described in sections (e) (2), (e) (3) and (e) (4) below, then payments will be made as follows:

i) from the available funds in the Delaware Hospital DSH Fund, the full amount of DSH payments or the total amount of the Delaware Hospital DSH Fund, whichever is less, will be made first to hospitals that qualify under section (d) above in accordance with section (e) (2) below. If the funds available are not sufficient to make the full payment amount to each hospital qualifying under section (e) (2), then the remaining funds will be allocated proportionately based on each hospital's percentage of the total payments due to all hospitals qualifying under section (e) (2).

ii) from the amount of any funds remaining in the Delaware Hospital DSH Fund after the payments described in section (e) (1) (C) (i) above, the full amount of DSH payments or the total amount remaining in the Delaware Hospital DSH Fund, whichever is less, will be made to hospitals that qualify under section (e) (3) below. If the funds remaining are not sufficient to make the full payment amount to each hospital qualifying under section (e) (3), then the remaining funds will be allocated proportionately based on each hospital's percentage of the total payments due to all hospitals qualifying under section (e) (3).

iii) from the amount of any funds remaining in the Delaware Hospital DSH Fund after the payments described in sections (e) (1) (C) (i) and (ii) above, payments will be made to other hospitals that qualify in accordance with section (e) (4) below. If the funds remaining are not sufficient to make the full payment amount to the other qualifying hospitals, then the remaining funds will be allocated proportionately based on each of the other qualifying hospital's percentage of the total payments due to all other qualifying hospitals in accordance with section (e) (4).

2) DSH Payments to Psychiatric Hospitals:

Per section 1923(h)(2)(A) of the Social Security Act, no more than 33 percent of the annual Federal DSH allotment for Delaware will be used with the appropriate amount of State matching funds to make an annual DSH payment to psychiatric hospitals that meet the Delaware DSH Criteria in sections (b) and/or (d) above. These annual DSH payments will be made in a lump sum to each qualifying hospital.

Unless the payment amount is restricted by other sections of this DSH policy, a psychiatric hospital that meets the criteria specified in section (b) but not section (d) above will receive a payment in accordance with section (e) (4) (A) or (C) below.

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Disproportionate Share Hospital (DSH) Payments (cont'd)

A psychiatric hospital that meets the criteria specified in section (d) above will receive a payment of 33 percent of the annual Federal DSH allotment for Delaware plus the appropriate amount of State matching funds minus the total amount of any payments made to other psychiatric hospitals

3) Payments to Hospitals that Meet the Delaware DSH Criteria in section (c) above

Unless the payment amount is restricted by other sections of this DSH policy, each hospital that meets the criteria specified in section (c) above shall receive an annual payment under Delaware's DSH program equal to the Hospital Specific DSH limit DSH payments will be made in a lump sum each year.

4) Payments to Hospitals that Meet the Delaware DSH Criteria in section (b) above
Unless the payment amount is restricted by other sections of this DSH policy, each hospital that qualifies under the criteria specified in section (b), but does not meet the criteria specified in sections (c) and (d) above will receive a payment of:

A) $10,000 if the hospital is a psychiatric hospital that does not meet the criteria specified in section (d) above and has been an enrolled provider with all participating Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for both inpatient and outpatient services offered by the hospital during the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment, or

B) $1,000,000 if the hospital is not a psychiatric hospital and has been an enrolled provider with all participating Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for both inpatient and outpatient services offered by the hospital during the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment; or

C) $5,000 if the hospital has not been an enrolled provider with all Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for both inpatient and outpatient services offered by the hospital during the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment.

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Disproportionate Share Hospital (DSH) Payments (cont'd)

(f) Application Process:

Each year after June 30, the Medicaid agency will compute the amount of funds available in the Delaware Hospital DSH Fund. After September 30 each year, the Medicaid agency will use the applications timely submitted by the hospitals to compile the data and perform any necessary calculations to determine the DSH payment amounts for each hospital. A hospital cannot qualify under section (b) (1) above unless a completed application is timely received from all hospitals in the state that receive Medicaid payments. The other qualifying criteria are hospital specific.

A hospital requesting Medicaid DSH payments must submit a completed application in a format approved by the Medicaid agency. The application must be received on or before September 30 of each year. The application will provide hospital specific inpatient and outpatient financial and other data for the hospital's fiscal year that ended in the prior calendar year.

On or before December 31 of each year, the Medicaid agency will send a written notice of action taken on each hospital's application. Each hospital that applied will be informed either that it does not qualify or that it qualifies and the amount of the hospital's DSH payment. Once a year, the Medicaid agency will issue the full DSH payment amount in a lump sum to hospitals that qualify for a payment.

In the initial year of the Delaware DSH program, the timing for submissions of applications for a hospital's fiscal year that ended in 2010 and the timing of payments to qualifying hospitals will be announced by the Medicaid agency after this DSH State Plan Amendment is approved.

(g) Audit Requirement:

Within one (1) year after receiving a DSH payment, the Medicaid agency will arrange for an independent audit of each hospital that receives a DSH payment in accordance with section 1923 (j) (2) of the Social Security Act. The auditor will take such steps as determined necessary to verify:

1) the extent to which the hospital reduced uncompensated care costs to reflect the total DSH payment received by the hospital; and

2) that the total amount of the DSH payment received by the hospital did not exceed the hospital-specific DSH payment limit; and

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Disproportionate Share Hospital (DSH) Payments (cont'd)

3) that only the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid and uninsured individuals as described in section 1923 (g) (1) (A) of the Social Security Act were included in the calculation of the hospital specific limit; and

4) that the hospital included all Medicaid payments, including supplemental payments, in the calculation of the hospital-specific limits.

The audit must also verify that DMMA has documented and retained a record of costs, claimed expenditures, uninsured costs, payments made on behalf of the uninsured and other pertinent information related to DSH payments.

(h) Disposition of Overpayments or Underpayments:

If the data upon which a DSH payment is based is revised as a result of an audit or for any other reason and if it is determined that a hospital was paid more than it should have received according to the rules of the program, the hospital is required to reimburse the state the full amount of the overpayment within 60 days of notification of the overpayment. The Medicaid agency will also recover DSH overpayments that exceed an individual hospital's DSH limit as defined at 1923(g) of the Social Security Act within 60 days of identifying the overpayment. The recovery will equal the amount of the DSH payment in excess of the hospital-specific DSH limit and amounts recovered by the Medicaid agency will not be redistributed. The Medicaid agency is authorized to recoup the full amount of the overpayment by withholding payments due to the hospital with the overpayment from claims being submitted to the program.

If the data upon which a DSH payment is based is revised as a result of an audit or for any other reason and if, based on the revised data, it is determined that a hospital was paid less than it should have received according to the rules of the program, no retroactive adjustments will be made by the Medicaid agency.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INPATIENT PSYCHIATRIC HOSPITAL CARE

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 0MB 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 under the heading Inflation Adjustment. 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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR INPATIENT HOSPITAL SERVICES CONTINUED

Freestanding Inpatient Rehabilitation Hospital Services

For claims with dates of discharge on or after December 2, 2014, the Delaware Medical Assistance Program (DMAP) shall reimburse freestanding Inpatient rehabilitation hospital services using the Medicare Inpatient Rehabilitation facility (IRF) Prospective Payment System (PPS).

The Medicare IRF PPS is based on a Patient Assessment Instrument (PAI). The PAI contains patient clinical and demographic information. The PAI classifies the patient into distinct groups based on their clinical characteristics and what the patient's expected resource needs will be. Separate payment rates are then calculated for each group.

Medicare rates are updated annually to reflect changes in local wages using the hospital wage index. Delaware Medicaid will follow Medicare policy on local wage rate increases.

The fee schedule and any annual/periodic adjustments to the fee schedule and effective dates are available on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

Except as otherwise noted in the plan, payment for these services is based on State-developed fee schedule rates, which are the same for both governmental and private providers of freestanding inpatient rehabilitation hospital services.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR UNDER AGE 21

1. Psychiatric Residential Treatment Facility (PRTF) Reimbursement
   Reimbursement for services are based upon a Medicaid fee schedule established by the State of Delaware. Psychiatric residential treatment facilities will be reimbursed the lesser of:
   - The Delaware Medicaid per diem reimbursement rate for activities in the per diem plus additional fee-for-service reimbursement using the Delaware Medicaid fee schedule for any other medical services under 1905(a) of the Social Security Act that children under age 21 who are residing in a PRTF are determined to need in order to correct or ameliorate health conditions, regardless of whether such services are identified in the child's plan of care, but not in the per diem PRTF reimbursement rate;
   - The facility's usual and customary charge to privately insured or private-pay beneficiaries; or
   - If an out of state facility, the lesser of a negotiated per diem reimbursement rate, the facility's usual and customary charge, or the Delaware Medicaid per diem rate. For any other medical services under 1905(a) of the Social Security Act that children under age 21 who are residing in a PRTF are determined to need in order to correct or ameliorate health conditions, regardless of whether such services are identified in the child's plan of care, that are not included in the per diem PRTF reimbursement rate, additional fee-for-service reimbursement using the Delaware Medicaid fee schedule is available.

   Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The Agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=17

   A. Community-Based Delaware Medicaid per diem PRTF reimbursement rate includes the following covered inpatient psychiatric residential treatment facility (PRTF) activities for individuals under twenty-one years of age:
      a. Behavioral Health care by staff who are not physicians
      b. Occupational Therapy / Physical Therapy / Speech Therapy
      c. Laboratory
      d. Transportation
      e. Diagnostics/radiology (x-ray)

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– INPATIENT PSYCHIATRIC CARE FOR UNDER AGE 21 CONTINUED

1. Psychiatric Residential Treatment Facility (PRTF) Reimbursement (continued)

B. Hospital-Based Delaware Medicaid per diem PRTF reimbursement rate includes the following covered inpatient psychiatric residential treatment facility (PRTF) activities for individuals under twenty-one years of age
   a. Behavioral Health care by staff who are not physicians
   b. Occupational Therapy / Physical Therapy / Speech Therapy
   c. Laboratory
   d. Transportation
   e. Dental
   f. Vision
   g. Diagnostics/radiology (x-ray)

C. Pharmaceuticals and physician activities provided to the youth in a PRTF, when on the active treatment plan of care, are components of the Medicaid covered PRTF service. These activities will be paid directly to the treating pharmacy or physician, using Medicaid pharmacy and physician fee schedule rates excluded from the psychiatric residential treatment facility (PRTF) State of Delaware Medicaid per diem reimbursement rates.

D. Any other medical services under 1905(a) of the Social Security Act that children under age 21 who are residing in a PRTF are determined to need in order to correct or ameliorate health conditions, regardless of whether such services are identified in the child's plan of care, that are excluded in A, B, or C above, shall be paid directly to the treating provider, using Medicaid fee schedule rates. Such services are excluded from the psychiatric residential treatment facility (PRTF) State of Delaware Medicaid per diem reimbursement rates.

E. The Medicaid PRTF per diem reimbursement rates shall also exclude any additional costs that are unrelated to providing inpatient psychiatric care for individual less than twenty-one (21) years of age including, but not limited to the following:
   1) Group education, including elementary and secondary education.
   2) Medical services that are not listed in Items A or B above.
   3) Activities not on the inpatient psychiatric active treatment plan.

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– INPATIENT PSYCHIATRIC CARE FOR UNDER AGE 21 CONTINUED

2. Psychiatric Residential Treatment Facility (PRTF) Reimbursement Rate Methodology

A. Medicaid certified providers will be reimbursed for covered PRTF services using a Medicaid per diem reimbursement rate consistent with the principles in section 1 above. The Medicaid per diem reimbursement rate paid to the provider will be determined by the following service criteria:

1) PRTF specializing in sexually-based treatment programs.
2) PRTF specializing in substance use disorder treatment programs.
3) PRTF treating children with mental health diagnoses.

The Delaware Medicaid PRTF fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

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Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 (B)

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☐ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example - 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

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Payment Adjustment for Provider Preventable Conditions

Claims for non-institutional services described in Attachment 4.19-B that includes a diagnosis code of E8765, E8766 or E8767 will be denied by Delaware Medicaid.

In compliance with 42 CFR 447.26(c), Delaware Medicaid provides:

1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

2) That reductions in provider payment may be limited to the extent that the following apply:

   I. The identified provider-preventable conditions would otherwise result in an increase in payment.
   II. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

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Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare sites of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting. Delaware Medicaid will maintain the Medicare rates throughout the year without any adjustments mirroring Medicare changes. Delaware is using a Deloitte fee schedule (which was based on the November 2012 Medicare release and the 2009 conversion factor). The methodology will also recognize Delaware's sole Medicare geographic locality.

☐ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

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Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment Continued

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

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Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment Continued

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99288	99324	99327	99335	99339	99359	99366	99374
99315	99325	99328	99336	99340	99363	99367	99375
99316	99326	99334	99337	99358	99364	99368	99376
99377	99380	99403	99407	99420	99442	99450	99261
99378	99401	99404	99411	99429	99443	99455	99262
99379	99402	99406	99412	99441	99444	99456	99263
99271	99274	99290	99295	99298	99301	99311	99321
99272	99275	99293	99296	99299	99302	99312	99322
99273	99289	99294	99297	99300	99303	99313	99323
99331	99351	99361	99372	99432	99436		
99332	99352	99362	99373	99433	99438		
99333	99353	99371	99431	99435	99440		

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Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment Continued

(Primary Care Services Affected by this Payment Methodology - continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99408 - Added October 10, 2010 99409 - Added October 10, 2010 99224 - Added January 1, 2011 99225 - Added January 1, 2011 99226 - Added January 1, 2011	90673 - Added July 2, 2014 99481 - Added July 2, 2014 99482 - Added July 2, 2014

Physician Services - Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate as implemented by the state in CYs 2013 and 2014.

☐ Medicare Physician Fee Schedule rate as implemented by the state and using the 2009 conversion factor.

☒ State regional maximum administration fee set by the Vaccines for Children program.

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Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment Continued

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $8.00 (eight dollars).

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

_____

_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

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OTHER TYPES OF CARE

Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment Continued

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at *(http://www.dmap.state.de.us/home/index.html).*

Vaccine Administration
This reimbursement methodology applies *to* services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at *(http://www.dmap.state.de.us/home/index.html).*

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respot1cl to a collection of information unless it displays a valid 0MB control number. The valid 0MB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data 11eeded, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-0S, Baltimore, Maryland 21244-1850.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Physician Services

Medical Payment for Primary Care Services

Payment for Primary Care Services

The state will continue to reimburse for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 CFR 447.400 remain in effect.

Primary care services eligible for enhanced payment include evaluation and management (E & M) services and vaccine administration services covered by the Delaware Medical Assistance Program (DMAP) and designated in the Healthcare Common Procedure Coding System (HCPCS).

Primary Care Physician Services Rendered On or After January 1, 2015:

- Primary care services rendered on or after January 11, 2015, that are eligible for payment pursuant to the requirements of 42 CFR 447.400(a), shall be paid at 100% of the Medicare physician fee schedule.
- The rates reflect all Medicare sites of service and locality adjustments.
- The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- The rates reflect all Medicare geographic/locality adjustments.
- If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and as published annually by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR 447.405 (a)(l).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Physician Services

Medicaid Payment for Primary Care Services CONTINUED

The DMAP will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (codes and date added specified).

99408 - Added October 10, 2010
99409 - Added October 10, 2010
99224 - Added January 1, 2011
99225 - Added January 1, 2011
99226 - Added January 1, 2011
90673 - Added January 1, 2014
99481 - Added January 1, 2014
99482 - Added January 1, 2014
90673 - Added July 2, 2014
99481 - Added July 2, 2014
99482 - Added July 2, 2014

DMAP did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (codes specified).

99288	99324	99327	99335	99339	99359	99366	99374
99315	99325	99328	99336	99340	99363	99367	99375
99316	99326	99334	99337	99358	99364	99368	99376
99377	99380	99403	99407	99420	99442	99450	99261
99378	99401	99404	99411	99429	99443	99455	99262
99379	99402	99406	99412	99441	99444	99456	99263
99271	99274	99290	99295	99298	99301	99311	99321
99272	99275	99293	99296	99299	99302	99312	99322
99273	99289	99294	99297	99300	99303	99313	99323
99331	99351	99361	99372	99432	99436		
99332	99352	99362	99373	99433	99438		
99333	99353	99371	99431	99435	99440		

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Physician Services

Medicaid Payment for Primary Care Services CONTINUED

Physician Services - Vaccine Administration Rendered On or After January 1, 2015

The vaccine administration rate will be the state regional administration fee set by the Vaccines for Children Program.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Physician Services

Medicaid Payment for Primary Care Services CONTINUED

Effective Date of Payment

a. Evaluation & Management Services

This reimbursement methodology applies to services delivered on or after January 1, 2015. The fee schedule and any annual/periodic adjustments to the fee schedule are available on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

Except as otherwise noted in the plan, State developed fee schedule rates are the same for both government and private providers.

b. Vaccine Administration

This reimbursement methodology applies to services delivered on or after January 1, 2015. The fee schedule and any annual/periodic adjustments to the fee schedule are available on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both government and private providers.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- OTHER TYPES OF CARE

Physicians, podiatry and independent radiology services shall be reimbursed based on CPT codes and definitions. Reimbursement rates shall be based on the Medicare Relative Value (RVU), adjusted by Geographic Practice Cost Indices (GPCI) representing the medical economic conditions specific to Delaware. Each CPT code has a unique RVU consisting of a Work Unit (WRVU), an Overhead Unit (ORVU), and a Malpractice Unit (MRVU). Delaware Medicaid may adjust the weight of each RVU up to, but not to exceed, 100% of the Medicare value.

Laboratories are reimbursed their usual and customary charge or a maximum fee for their service, whichever is lower. The maximum fee for each procedure will be reviewed annually. If such review indicates that fees should be modified, an inflation factor will be considered to apply to the fees which are currently in place; in addition, other aspects of the fee structure will be examined in light of usual and customary charges and other pertinent considerations to develop appropriate rates for the year.

Physician Assistant services, provided under the supervision, control, and direction of one or more physicians, are billed under a supervising physician's provider number, with the Physician Assistant's provider number included as the rendering provider. Physician Assistant's may not bill Medicaid directly.

This reimbursement methodology applies to services delivered on or after January 1, 1995. The fee schedule and any annual/periodic adjustments to the fee schedule are available on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

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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, Al. 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 l. 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 l. 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.

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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.

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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

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Medical free-Standing Clinics that are licensed as a free standing emergency room under section 4404 of Title 16 of the Delaware Administrative Code are paid a negotiated flat rate per encounter. Dialysis clinics are paid 100% of the applicable Medicare rate. All other medical clinics are paid as physicians are paid as described in Attachment 4. 19-B Other Types of Care, Physician, Podiatry and Independent Radiology Services. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private medical free-standing clinics.

The agency's fee schedule for free standing emergency rooms was set as of April 1, 2005 and is effective for services provided on or after that date. The fee schedule and any periodic adjustments are published on the DMAP website at: http://www.dmap.state.de.us/downloads.html.

Dental free-Standing Clinics are paid the same as non-clinic dentists per EPSDT Dental Treatment, Attachment 4.19-B page 19.

School-Based Wellness Center (SBWC) Clinic Services

1. Payment Methodology: SBWC Clinic Services are reimbursed based on a prospective single visit per day for each day on which a medical service is provided effective for dates of service on or after October 1, 2010. The visit rate shall be calculated by dividing provider costs for the prior year by actual visits for the prior year submitted in a format specified by the Medicaid agency. The State-developed prospective visit rates for this service are the same for both governmental and private providers of this service.

2. UPL Calculation: Payments for clinic services will not exceed the upper payment limits set forth in 42 CFR 447.321. Providers will complete the Delaware Medicaid SBWC Cost Report annually within four months after the close of each fiscal year. The Medicaid SBWC Cost Report is based on the Medicare FQHC Cost Report (CMS 222) adjusted to account for the difference in the operating period for the SBWCs from a full year clinic. The actual annual visits as reported on the Cost Report shall be used as the denominator to calculate a visit rate that approximates a Medicare rate. The Medicare rate will be multiplied by the annual aggregate Medicaid visits for dates of service in the applicable state fiscal year to approximate the Medicare payment which will be compared to the actual payments for the fiscal year to determine whether the upper payment limit test is met.

EPSDT Services are reimbursed as follows:

See Page 19

Family Planning Clinic Services are reimbursed a flat fee per service. The fee schedule is established as of October 1 of each year. Family Planning providers are notified of the rates for family planning services. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers of family planning services and the fee schedule is available to providers upon request.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Transportation Services are reimbursed as follows:

1. Emergency Transportation: Effective for dates of service on or after January 1, 2012, emergency transportation is reimbursed as a percentage of the Medicare Fee Schedule for Delaware as follows:

- Ground Mileage, per Statute Mile will be 22%
- Advanced Life Support. Emergency Transport will be 13%
- Basic Life Support, Emergency Transport will be 17%
- Conventional Air Services. Transport One Way (Rotary Wing) will be 39%
- Rotary Wing Air Mileage, per Statute Mile will be 38%

2. Non-emergency Transportation: The broker is reimbursed a monthly capitated rate for each Medicaid client residing in the State.

Optometrist and Opticians are reimbursed for examinations as physicians are paid as described in Attachment 4.19-B Other Types of Care, Physician, Podiatry and Independent Radiology Services.

Except as otherwise noted in the Plan, State-developed fee schedule rates are the same for both governmental and private individual practitioners. The fee schedule and any annual/periodic adjustments to the fee schedule are published and found at: https://www.dmap.state.de.us/downloads/hcpcs.html.

Spectacle frames and lenses and contact lenses and reimbursed based on Level II HCPCS procedure codes. The agency's fee schedule rate for these procedure codes was set on July 1, 2002 and is available on the DMAP website.

Out-of-State Services, for which Delaware has established a universal rate or cap, will be reimbursed at the provider's usual and customary charge or Delaware's rate/cap, whichever is lower.

Where there is no universal rate/cap (i.e. providers are paid a provider-specific rate), Delaware Medicaid will establish a rate or cap that is consistent with the reimbursement methodology defined in other sections of Attachment 4.19-B for that specific service and pay the provider the lower of that rate/cap or their usual and customary charge.

Extended Services to Pregnant Women - Government providers are reimbursed on a negotiated rate basis which will not exceed actual costs which result from efficient and economic operation of the provider. Reimbursement of non-governmental providers will be based on reasonable charges which will not exceed the prevailing charges in the locality for comparable services as determined from the annual DMAP Nursing Wage Survey. The agency's fee schedule rate was set as of June 1, 2002 and is effective for services on or after that date. The fee schedule and any periodic adjustments are published on the DMAP website at: http://www.dmap. state.de.us/downloads.html.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Tobacco Cessation Counseling Services

To maximize the effectiveness of tobacco cessation medications, counseling services are available for Medicaid beneficiary use in conjunction with cessation medication.

Counseling services must be prescribed by a licensed practitioner participating in the Delaware Medical Assistance Program (DMAP).

Clinicians and other licensed practitioners must bill their usual and customary charges and must use the appropriate CPT/CDT Codes to bill for their counseling services. Services supplied by contracted vendors are reimbursable under the terms of the agreement with the State of Delaware.

State developed fee schedule rates and any annual periodic adjustments to the fee schedule and its effective dates are published at http://www.dmap.state.de.us/downloads/hcpcs.html

Assurances - Cost Sharing Exemption for Tobacco Cessation Services

The State assures that cost-sharing is prohibited for tobacco cessation services for pregnant women. In accordance with Section 1916(a)(2)(B) and section 1916A(b)(3)(B)(iii) of the Act, the State does not permit cost sharing for services furnished to pregnant women, if such services are related to the pregnancy or to any other medical condition which may complicate the pregnancy. The State assures that the prohibition on cost-sharing for pregnant women specifically includes "counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))."

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Other Licensed Behavioral Health Practitioners

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Delaware.

If a Medicare fee exists for a defined covered procedure code, then Delaware will pay Psychologists at 100% of the Medicaid physician rates as outlined under Attachment 4.19-B, item 5. If a Medicare fee exists for a defined covered procedure code, then Delaware Medicaid will pay Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors of Mental Health (LPCMH), Licensed Marriage and Family Therapists (LMFTs) at 75% of the Medicaid physician rates as outlined under Attachment: 4.19-B, item 5.

When Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, is required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The Agency's fee schedule rate was set as of October 2, 2013 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at www.dmap.state.de.us/downloads/hcpcs.html.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

Other Licensed Behavioral Health Practitioners Continued:

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses - Benefits, Employer Taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider overhead Expenses
- Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

(RESERVED FOR FUTURE USE)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

REHABILITATIVE SERVICES

Crisis Intervention Behavioral Health Services

Reimbursement for crisis intervention services as outlines per Attachment 3.1-A, page 6a is paid based upon a Medicaid fee schedule established by the State of Delaware.

If a Medicare fee exist for a defined covered procedure code, then Delaware will pay Psychologist at 100% of the Medicaid physician rates as outlined under Attachment 4.19-B, item 5. If a Medicare fee exist for a defined covered procedure code, then Delaware will pay Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFTs) at 75% of the Medicaid physician rates as outlined under 4.19-B, item 5.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicaid rate, where there is a comparable Medicare rate. Room and board cost are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The Agency's fee schedule rate was set as of October 2, 2013 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at www.dmap.state.de.us/downloads/hcps.html.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

REHABILITATIVE SERVICES

Addiction Services Rehabilitative Health Services

Reimbursement for outpatient addiction services as outlined per Attachment 3.1-A, page 6g and residential treatment services as outlined per Attach1nent 3.1-A page 6i are paid based upon a Medicaid fee scheduled established by the State of Delaware.

If a Medicare fee exists for a defined covered procedure code, then Delaware will pay Psychologists at 100% of the Medicaid physician rates as outlined under 4.19·B, item 5. If a Medicare fee exists for a defined covered procedure code, then Delaware will pay Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors of Mental Health (LPCMH), Licensed Chemical Dependency Professionals (LCDPs), Licensed Marriage and Family Therapists (LMFTs) at 75% of the Medicaid physician rates as outlined under 4.19-B, item 5.

Where Medicare fees do not exist for a covered code, the fee development methodology for both outpatient and residential rates will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to **beneficiaries** at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs care not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The agency's fee schedule rate was set as of October 2, 2013 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at www.dmap.de.us/downloads/hcpcs.html.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

REHABILITATIVE SERVICES

Addiction Services Rehabilitative Health Services Continued

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages.
- Employee-related expenses-benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g. supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

HOME HEALTH SERVICES

42 CFR 440.70

Home Health Services are reimbursed as follows:

Home Health Services are reimbursed in accordance with 42 CFR 440.70 and when provided as defined in Attachment 3.1-A of this State Plan, subject to the requirements of 42 CFR 441.15 and 42 CFR 441.16.

Payment for Home Health Services shall be reimbursed as follows:

The rates are prospective and are arrayed to determine the seventy-fifth (75th) percentile for each procedure code. The 75th percentile refers to the array of rates with regard to the Delaware Medicaid enrolled providers at the time of the new rate methodology consideration. The rates are then inflated by the four (4) quarter moving average within the CMS Home Health Market Basket Index. The Inflated average cost is per fifteen (15) minutes for each procedure code. Supply cost will be reimbursed as part of the skilled nursing and home health aide prospective rates.

An inflation factor will be applied to the prior year's rates to determine the current year's rates. The inflation indices are obtained from the CMS Home Health Market Basket Index.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health services. The agency's fee schedule rate was set as of October 2, 2015 and is effective for services provided on or after that date. Fee schedules for home health services are available on the Delaware Medical Assistance Program (DMAP) website at http://www.dmap.state.de.us/downloads/feeschedules.html.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

HOME HEALTH SERVICES

42 CRF 44.70

The agency's fee schedule rate is based upon the Home Health cost of services for a Home Health Aide, Skilled Nurse, Physical Therapist, Occupational Therapist, and Speech Therapist.

The agency's fee schedule rate was set as of October 2, 2015 and is effective for services provided on or after this date. The fee schedule and any annual periodic adjustments to the fee schedule are published on the Delaware Medical Assistance Program (DMAP) website at:
http:/www.dmap.state.de.us/downloads/freeschedule.html

Except as otherwise notes in the plan, State-developed fee schedule rates are the same for both government and private providers.

Prescribed Pediatric Extended Care Centers (PPECCs) will be reimbursed at a negotiated range of daily rates depending on the level of care needed by each child.

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DELAWARE RATES FOR OBSTETRICAL CARE

59000	**Amniocentesis**	$51 .70
59012	*Code not currently used*	
59015	Chorionic villus sampling, any method	$133.25
59020	Fetal oxytocin stress test, complete Total	$39.04
	Professional Component	$15.83
59025	Fetal non-stress test, complete...Total	$30.00
	Professional Component	$15.83
59030	Fetal scalp blood sampling	IC*
59050	Internal fetal monitoring	$126.60
59051	interpretation only	$55.81
59100	Hysterotomy	IC*
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian requiring salpingectomy and/or oophorectomy	$442.05
59121	tubal or ovarian, without salpingectomy and/or oophorectomy	$512.73
59130	abdominal pregnancy	$580.25
59135	interstitial, uterine pregnancy requiring total hysterectomy	$525.39
59136	interstitial, uterine pregnancy with partial resection of uterus	$525.39
59140	cervical, with evacuation	$808.13
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	$373.20
59151	with salpingectomy and/or oophorectomy	$525.30
59160	Curettage, postpartum (separate procedure	$163.53
59200	Insertion of cervical dilator	$43.69
59300	Episiotomy or vaginal repair; by other than attending physician	$94.42
59320	Cerclage of cervix, during pregnancy; vaginal	$90.00
59325	abdominal	IC*
59350	Hysterorrhaphy of ruptured uterus	$348.30
WW303	Initial prenatal visit	$49.00
59400	*Code not currently used*	
59409	Vaginal Delivery only (with or without episiotomy and/or forceps)	$600.00
59410	Routine delivery	$ 680.00
59412	*Code not currently used*	
59414	Delivery of placenta (separate procedure)	$94.80
59420	Prenatal visit	$35.00
59414	Delivery of placenta (separate procedure)	$ 94.80
59420	Prenatal visit	$ 35.00
59425	*Code not currently used*	
59426	*Code not currently used*	
59430	Postpartum care only	$ 35.00
59510	*Code not currently used*	

* IC = individual consideration

59514	Cesarean delivery only	$600.00
59515	including postpartum care	$680.00
59525	Subtotal or total hysterectomy after cesarean delivery	$353.40
59812	Treatment of incomplete abortion, any trimester completed surgically	$211.00
59820	Treatment of missed abortion, completed surgically; completed surgically: first trimester	$200.45
59821	second trimester	$ 284.87
59830	Treatment of septic abortion, completed surgically	$166.16
59840	Induced abortion, by dilation and curettage	$321 .78
59841	Induced abortion by dilation and evacuation	IC*
59850	Induced abortion, by one or more intra-amniotic injections	$379.80
59851	with dilation and curettage and/or evacuation	$358.70
59852	with hysterotomy (failed intra-amniotic injection) IC*	IC*
59855	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, luminaria)	$333.77
59856	with dilation and curettage and/or evacuation	$503.51
59857	with hysterotomy (failed medical evaluation)	$612.45
59870	Uterine evacuation and curettage for hydatidiform mole	$248.27
59899	Unlisted procedure, maternity care and delivery	IC*

*IC = individual consideration

DELAWARE RATES FOR PEDIATRIC CARE

New patient office visits

99201		$25.00
99202		$40.00
99203		$60.00
99204		$85.00
99205		$105.00

Established patients office visits

99211		$12.50
99212		$20.00
99213		$39.00
99214		$50.00
99215		$75.00

New or established office or other outpatient consultation

99241		$25.00
99242		$35.00
99243		$50.00
99244		$75.00
99245		$120.00

New or established patient confirmatory consultations
99271 through 99275 Codes not currently used

New patient home services

99341		$32.60
99342		$45.47
99343		$54.78

Established patient home services

99351		$32.12
99352		$38.71
99353		$45.10

Prolonged Services

99354	Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	$100.00
99355	each additional 30 minutes	$45.00
99358	*Code not currently used*	
99359	*Code not currently used*	

99371 through 99373 Codes not currently used

New patient preventive medicine services
99381 through 99384 Codes not currently used

*IC = individual consideration

Established patient preventative medicine services

99391		$31.00
99392		$31.00
99393		$31.00
99394		$31.00

New or established consulting and/or risk factors reduction intervention
99401 through 99429 Codes not currently used

Newborn care

99431	Newborn care	$48.00
99432	New born care in other than hospital/birthing room setting	$48.00
99433	Normal newborn subsequent hospital care	$32.00
99440	Newborn resuscitation; care of high risk newborn	$85.00
94772	Pediatric Pneumogram	IC*

Immunizations

90700	DTaP - *Covered through Immunization Program*	
90701	DTP - *Covered through Immunization Program*	
90702	OT - *Covered through Immunization Program*	
90703	Tetanus toxoid	$2.20
90704	Mumps virus vaccine, live	IC*
90705	Measles virus vaccine, live, attenuated	$16.85
90706	Rubella virus vaccine, live	$16.80
90707	MMR	$27.25
90708	MR	$16.90
90709	Rubella & Mumps	IC*
90710	Measles, mumps, rubella, and varicella vaccine	IC*
90711	Diphtheria, tetanus, and pertussus (DPT) and injectable poliomyelitis vaccine - *Covered through Immunization Program Only*	
90712	PV - *Covered through Immunization Program Only*	
90713	Poliomyelitis	$20.17
90714	Typhoid vaccine	IC*
90716	Varicella (chicken pox) vaccine - *Covered through Immunization Program Only*	
90717	Yellow fever vaccine	IC*
90718	Tetanus & Diptheria toxoids absorbed	$2.60
90719	Diphtheria toxoid	IC*
90720	Diphtheria, tetanus, and pertussis (DPT) and Hemophilus influenza B (HIBi vaccine - *Covered through Immunization Program Only*	
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaPI and Hemophilus influenza B (HIB) vaccine - *Code not currently used*	

*IC = individual consideration

90724	Influenza virus vaccine	$4.38
90725	Cholera vaccine	IC*
90726	Rabies vaccine	$93.00
90727	Plague vaccine	IC*
90728	BGC vaccine	IC*
90730	Hepatitis A vaccine	IC*
90731	Hepatitis B - *Covered through Immunization Program Only*	
90732	Pneumococcal vaccine, polyvalent	$8.60
90733	meningococcal polysaccharide vaccine (any group (s))	$45.00
90737	Hemophilus influenza B – *Covered through Immunization Program Only*	
90741	Immunization, passive; human (ISG)	$38.00
90742	Specific hyperimmune serum globulin	IC*
90744	Immunization, active, hepatitis B vaccine; newborn to 11 years -*Code not currently used*	
90745	11 - 19 years - *Code not currently used*	
90749	Unlisted immunization procedure	IC*
WW224	DTaP - *Covered through Immunization Program Only*	
WW226	DPT & HIB - *Covered through Immunization Program Only*	

Delaware implemented a HCFA approved 1115 Demonstration waiver (the Diamond State Health Plan-DSHP) on 1/1/96. Participates in the DSHP include most Medicaid eligible pregnant women and children including:

- AFDC & AFDC/UP recipients
- Pregnant women and infants with family below 185 % of poverty
- Children up to age 6 with family incomes below 133% of poverty
- Children up to age 19 with family income at or below 100% of poverty
- SSI recipients
- Disabled children under 42 CFR §435.225

Each DSHP participant chooses or is assigned to a primary care physician (PCP) who is responsible for providing primary care services, including EPSDT services. The PCP also either provides or refers the participant for pediatric and, for women of childbearing years, obstetrical/gynecological services.

The implementation of the DSHP assures access to pediatric and 0B/GYN services which meets the Medicaid State Plan requirements for payment of and access to these services and the DSHP waiver requirements.

*IC = individual consideration

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR PRIVATE DUTY NURSING SERVICES
42 CRF 440.80

Private duty nursing (PDN) services provided to eligible Delaware Medical Assistance Program (DMAP) individuals are reimbursed using prospectively determined rates. The unit of service for agency providers is one (1) hour. A weekly maximum limit is established for each individual by the DMAP based on the authorized services.

Rates for agency services are reviewed annually. The rate will relate to the lowest prevailing usual and customary charge, as determined by a survey of all private duty nursing service agencies. Agencies will be reimbursed the lower of their usual and customary charges or the maximum rate.

Providers are not required to submit cost reports to the DMAP. There are no retrospective settlements on claims paid.

The baseline PDN reimbursement rate will normally represent services provided by one nurse to one individual. An adjusted reimbursement rate per individual will be established for medically necessary PDN services provided by a single nurse for up to three (3) clients. Maximum rates are established according to the following table:

One individual:	Rate for One =	100% of established baseline rate
Two individuals:	Rate for Each =	50% of 143% of baseline rate
Three individuals:	Rate for Each =	33% of 214% of baseline rate

The fee schedule and any annual/periodic adjustments to the fee schedule and effective dates are available on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

The rates of service were set as of October 2, 2015 and are effective for services provided on or after that date.

Except as otherwise noted in the plan, payment for these services is based on State-developed fee schedule rates, which are the same for both governmental and private providers of freestanding inpatient rehabilitation hospital services.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Durable Medical Equipment, Appliances, Prosthetics, Orthotics, and Supplies

42 CFR 440.70

In accordance with 42 CFR 440.70, the Delaware Medical Assistance Program (DMAP) will reimburse Durable Medical Equipment (DME) providers for the purchase/rental of medical equipment, appliances, orthotics and prosthetics and the purchase of medical supplies when ordered by a medical practitioner.

Effective October 2, 2015, reimbursement for Durable Medical Equipment (DME) is determined by the DMAP based on one of the following:

- The Medicare fee schedule received yearly from the Region A - Durable Medical Equipment Regional Carrier (DMERC) OR
- Information received from the DME provider such as catalog pages that include manufacturer's name, item model number, and costs or a copy of the company's invoice that describes the item and gives an itemized explanation of all charges.(It is not permissible for the DME provider to "roll in" other expenses such as labor, delivery, fittings, etc.).

Except where there is a Medicare fee established, DMAP pays the lower of:

- Provider's usual and customary charges
- Cost + 20% (includes administration fee)
- List price.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Durable Medical Equipment, Appliances, Prosthetics, Orthotics, and Supplies

42 CFR 440.70

Augmentative and Alternative Communication Devices/Systems

Effective October 2, 2015 the reimbursement for augmentative and alternative communication devices/systems is determined based on documented actual cost to the provider for the device plus twenty percent (20%) on the first $1,000 and five percent (5%) on the balance, or the provider's usual and customary charge for the device, whichever is lower.

The agency's fee schedule rate was set as of October 2, 2015 and is effective for services provided on or after this date. The fee schedule and any annual periodic adjustments to these rates are published on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both government and private individual providers.

Certified Nurse Practitioners will be reimbursed in the same way that physicians are reimbursed, the lesser of their usual and customary charge or the capped fee per HCPCS procedure code.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

FEDERALLY QUALIFIED HEALTH CENTERS

The Centers for Medicare and Medicaid Services (CMS) requires that Federally Qualified Health Centers (FQHCs) be reimbursed in compliance with the Benefits Improvement and Protection Act (BIPA) of 2000. Effective July 1, 2018, Delaware Medicaid shall reimburse each FQHC per-visit through one of the following two (2) methodologies:

1. A prospective payment system (PPS) rate, where 100 percent of the reasonable costs based upon an average of their fiscal years 1999 and 2000 audited cost reports are inflated annually by the Medicare Economic Index (MEI). or
2. For FQHCs that elect this method, an Alternative Payment Methodology (APM), equal to the per-visit cost as reported by the FQHC in its most recent cost report, subject to an audit performed by a certified public accountant as to the reasonableness of the reported costs.

The APM described in methodology option two (above) shall pay at least the PPS rate. Any FQHC that elects to be reimbursed for services under the APM shall sign an agreement with the Delaware Medicaid Program acknowledging this decision.

Managed Care Supplemental Payment - APM

The Medicaid Managed Care Organizations are contractually required to include the same service array and the same payment methodology as the State Medicaid FFS contracts with FQHCs. The Delaware Medicaid Program will verify that the FQHC has received [for every visit at least the PPS rate as calculated by methodology option one (above) or the APM rate, in the event the FQHC elected to be reimbursed via methodology option two (above). For Delaware Medicaid FQHC reimbursement purposes, a wraparound payment shall be defined as the difference between payment under the PPS or APM methodology and payment provided under the Managed Care contract. If there is a discrepancy in payment amounts, the Medicaid Managed Care Organization will make a wraparound payment to the FQHC within 90 days following the date the claim was submitted. Per the Social Security Act, Section 1902(bb)(5)(A) and (B)The wraparound payment schedule shall be agreed to by the State and FQHC and will be no less frequent than every four months. An annual reconciliation shall occur within 120 days after the end of each State Fiscal Year.

Managed Care Supplemental Payment

The Medicaid Managed Care Organizations are contractually required to include the same service array and the same payment methodology as the State Medicaid FFS contracts with FQHCs. The Delaware Medicaid Program will verify that the FQHC has received for every visit at least the PPS rate as calculated by methodology option one (above) or the APM rate, in the event the FQHC elected to be reimbursed via methodology option two (above). For Delaware Medicaid FQHC reimbursement purposes, a wraparound payment shall be defined as the difference between payment under the PPS or APM methodology and payment provided under the Managed Care contract. If there is a discrepancy in payment amounts, the Medicaid agency will make a wraparound payment to the FQHC within 90 days following the date the claim was submitted. Per the Social Security Act, Section 1902(bb)(5)(A) and (B). The wraparound payment schedule shall be agreed to by the State and FQHC and will be no less frequent than every four months. An annual reconciliation shall occur within 120 days after the end of each State Fiscal Year.

☒ The rate year for FQHC services is July 1 through June 30.

☒ The payment methodology for FQHCs will conform to section 702 of the BIPA 2000 legislation.

The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE
REIMBURSEMENT FOR PHARMACEUTICALS

Overview

The Delaware Medical Assistance Program (DMAP) will reimburse pharmaceuticals using the lower of:

- The usual and customary (U & C) charge to the general public for the product,
- National Average Drug Acquisition Cost (NADAC),
- Wholesale Acquisition Cost (WAC),
    - o WAC for legend
    - o WAC minus 2% for non-legend
- Delaware Maximum Allowable Cost (DMAC), or
- Actual Acquisition Cost (AAC).

DMAP will meet the reimbursement of FUL defined drugs in the aggregate by reviewing that the NADAC does not exceed the FUL levels.

Methodology for establishing AAC is provided in the table on page Attachment 4.19-B Page 14a.

Entities that purchase Section 340B of the Public Health Service Act products must request to use these drugs for all DMAP patients, including Medicaid fee-for-service patients and for patients whose care is covered by Medicaid Managed Care Organizations.

Professional Dispensing Fee

There is one-time professional fee per thirty (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:

- When a single source product has Average Selling Prices provided by the manufacturer that indicates the WAC is exaggerated,
- When the NADAC does not reflect the most current cost of a multiple source drug, or
- If a single provider agrees to a special price.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE
REIMBURSEMENT FOR PHARMACEUTICALS

Reimbursement Policy:

The lower of Usual and Customary or Actual Acquisition Cost (AAC) for Drug Reimbursement is derived using the methodology in the table below.

Category	Ingredient Cost	Professional Dispensing Fee
Brand Drug	NADAC	$10
Generic Drug	NADAC	$10
Drugs Without NADAC	WAC for legend and WAC-2% for non-legend; or a Delaware Maximum Allowable Cost, whichever is lower.	$10
340B Purchased Drug	AAC for dispensed drugs	$10
	AAC for physician administered drugs	$0
Contract 340B Pharmacy	Drugs acquired through the Federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered.	N/A
Drugs purchased by 340B entities enrolled with DMMA as utilizing public health service products, which based on specific conditions, must purchase drugs outside of the 340B inventory when that drug is not available or eligible for 340B purchase.	NADAC	$10
Federal Supply Schedule	AAC	$10
Drugs Acquired at Nominal Price	AAC	$10
Specialty Drugs-Mailed	AAC (Invoice price)	$27
Drug Not Dispensed by Retail Pharmacy	NADAC or WAC, whichever is lower.	$10
Physician Administered Drugs	AAC based on invoice price if maximum unit cost is greater than or equal to $50. For drugs where the maximum cost is less than $50, the cost will be based on direct price or Average Sales Price plus 6%.	N/A
Clotting Factor	AAC (Invoice Price)	$27
Investigational Drugs (when prior authorized; as a general rule not covered products)	AAC	$10

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REIMBURSEMENT FOR PHARMACEUTICALS

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES
STATE PLAN PERSONAL CARE SERVICES

Personal Care Services:

The payment methodology for Personal Care Services described below will sunset on December 31, 2015 as covered of PCS be provided under Home Health Services benefit.

Payment for personal care services is based on a fee for service, the rate for which is set by a rate setting committee (including representatives of the Department of Health and Social Services' Divisions of Social Services, Management Services, and Alcohol, Drug Abuse and Mental Health) on an annual and provider specific basis.

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Reimbursement methodology for *Day Health and Rehabilitation Services* for individuals who could benefit from services designed for, or associated with Mental Retardation or Developmental Disabilities

Rates for Day Health and Rehabilitation Services, as defined in Attachment 3.1-A, will be daily rates established for the defined levels by a rate setting committee composed of representatives of various Divisions of the Delaware Department of Health and Social Services, including the Division of Social Services (DSS), the Division of Management Services (DMS), the Division of Alcoholism, Drug Abuse and Mental Health (DADAMH, and the Division of Mental Retardation (DMR).

Rates are provider specific and are calculated by determining total costs for each provider at each level of service, including cost of services to all clients regardless of Medicaid eligibility.

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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.

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(RESERVED FOR FUTURE USE)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Dental Services

Dental Services are reimbursed as follows. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both government and private providers.

Dental Services -Effective for dates of service on or after July 1, 2017, Delaware pays for dental services at the lower of:

- the provider's billed amount that represents their usual and customary charge; or
- the Delaware Medicaid maximum allowed amount per unit per covered dental procedure code according to a published fee schedule.

The Delaware Medicaid dental fee schedule will be developed based on the National Dental Advisory Service (NDAS) annual Comprehensive Fee Report. For each covered dental procedure code, Delaware's maximum allowable amount will be computed as a percentage of the NDAS published national fee. Delaware will rebase its dental fee schedule rates each time the NDAS publishes a new survey.

Preventive General Dental Services shall be paid at 61.00% of the NDAS 70th percentile amounts
Restorative General Dental Services shall be paid at 84.60% of the NDAS 70th percentile amounts
Adjunctive General Dental Services shall be paid at 72.24% of the NDAS 70th percentile amounts
Specialty Dental Services shall be paid at 68.80% of the NDAS 80th percentile amounts

Access-Based Fees for certain specialty procedure codes may be established to account for deficiencies in rates that are based on the NDAS fee schedule percentages above relating to the adequacy of access to health care services for Medicaid clients.

The maximum allowed amounts for procedure codes not included in the NDAS fee schedule or for new procedure codes established after the annual NDAS fee schedule is published will be based on the existing rates for similar existing services. If there are no similar services the maximum allowed amount is set at 80% of the estimated average charge until a rate can be established based on the NDAS fee schedule.

The dental fee schedule is available on the Delaware Medical Assistance Portal
https://medicaid.dhss.delaware.gov

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
Rehabilitative Mental Health Services and Substance Use Disorder Services

Reimbursements for services are based upon a Medicaid fee schedule established by the Delaware Medical Assistance Program (DMAP).

The fee development methodology built fees considering each component of provider costs as outlined below. These reimbursement methodologies produced rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule is equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations.

The Agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at http://www.dmap.state.de.us/downloads/feeschedules.html.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES CONTINUED

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Rehabilitative Mental Health Services and Substance Use Disorder Services Continued

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development:

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units. A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

5. Other EPSDT Services

Reimbursement for services not otherwise covered under the State Plan is determined by the Medicaid agency through review of a rate setting committee. Non-institutional services are paid on a fee-for-service basis. Institutional services are per diem rates based on reasonable costs. These services include:

(a) Prescribed Pediatric Extended Care - see ATT. 4.19-B, Page 7

(b) School-Based Health Service (SBHS) Providers:

School based health service providers include Delaware school districts and charter schools and may provide the following Medicaid services per Attachment 3.1-A, Page 2 Addendum:

- EPSDT Screens
- Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy, Language and Hearing Services
- Psychological and Developmental Treatment Assessment
- Counseling and Therapy
- Residential Mental Health or Developmental Disability Treatment
- Specialty Transportation Services

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
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(d) School-Based Health Service (SBHS) Providers Continued:

Direct Medical Payment Methodology for SBHS Providers

Effective for dates of service on or after July 1, 2008, covered SBHS provided or purchased by Local Education Agency (LEA) providers will be paid on a cost basis. Providers will initially be reimbursed using DMMA interim fee for service rates for SBHS direct medical services per specified unit of service. Fee for service rates include allowable direct costs (salaries, benefits, purchase of service and other costs directly related to the delivery of the medical services) and indirect costs, allocated as part of an Indirect Cost Plan per 0MB Circular A-87 that must be approved by the cognizant agency. These rates are specific to the Local Education Agencies. Rates must be consistent with efficiency, economy and quality of care. The interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for the period covered by the interim rates. On an annual basis, a District or school-specific cost reconciliation and cost settlement will be processed for all over and under payments.

Computation of SBHS Interim FFS Rates

The interim rate will be computed for each procedure code based on actual costs incurred in the prior state fiscal year. The interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for the period covered by the interim rates. On an annual basis, a District or school-specific cost reconciliation and cost settlement will be processed for all over and under payments.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
-OTHER TYPES OF CARE

(d) School-Based Health Service (SBHS) Providers Continued:

Determination of Actual LEA Costs via Annual Cost Reporting Process

Actual total direct and indirect cost of providing health-related services, less any federal payments for these costs, will be determined using the following data sources:

1. School Based Health Services Cost Reports

Each provider will complete an annual cost report for all school based health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before October 31 of the fiscal year following the reporting period. The primary purposes of tl1e cost report are to:

- Document the provider's total Medicaid allowable costs for delivering school based health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
- Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual Cost Reports are subject to a desk review by the Department of Health and Social Services (DHSS) or its designee.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

(d) School-Based Health Service (SBHS) Providers Continued:

Allowable Costs shall include:

a. Direct Medical Services including Salaries, Benefits and contracted medical services which may be traced directly to the provider's audited yearly trial balance.
b. Indirect Costs using the provider specific Unrestricted Indirect Cost Rate (UICR) applicable for the dates of service in the rate year. The UICR is the unrestricted indirect cost rate approved by Delaware's cognizant agency for education services, the U.S. Department of Education.

2. Direct medical percentage as determined by the CMS Approved Time Study data.

The time study is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. This time study methodology will utilize two mutually exclusive cost pools representing individuals performing Direct Medical Services: one for nursing staff and one for all other healthcare professionals. A sufficient number of personnel for each cost pool will be sampled to ensure time study results that will have a confidence level of at least 95 percent (95%) with a precision of plus or minus five percent (5%) overall. The Direct Medical Service time study percentage is applied against the Direct Medical Service cost pool. Results will be District-wide so every school will have the same time study percentages.

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(d) School-Based Health Service (SBHS) Providers Continued.

3. School District-specific IEP Medicaid Eligibility Rates (MER)

A District-wide MER will be established that will be applied to all participating schools. When applied, this MER will discount the Direct Medical cost pool by the percentage of Medicaid students with IEPs.

The names and birthdates of students with a health-related IEP will be identified from ESchool Plus, the statewide pupil accounting system and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The numerator of the rate will be the students with an IEP that are eligible for Medicaid, and the denominator will be the total number of students with an IEP.

Computation of Total Medicaid Reimbursable Cost

For each district or school participating in the Delaware Medicaid program, the SBS Allowable Costs from Step 1 will be multiplied by the Direct Medical Percentage from Step 2. The product will then be multiplied by the Medicaid Eligibility Rate from Step 3 to determine the total Medicaid reimbursable cost for each participating provider.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

(d) School-Based Health Service (SBHS) Providers Continued:

Specialized Transportation Services Payment Methodology

Specialized transportation services are paid on a cost basis. Providers will initially be reimbursed using a DMMA interim fee for service rate per trip for specialized transportation services.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Attendants
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Contractors payments
7. Other Operating Expenses
8. Depreciation

Special education transportation costs include those adapted for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities. On an annual basis, a cost reconciliation and cost settlement will be processed for all over and under payments.

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OTHER TYPES OF CARE

(d) School-Based Health Service (SBHS) Providers Continued:

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Transportation is specifically listed in the IEP as a required service;
2. The child requiring transportation in a vehicle with personnel specifically trained to serve the needs of an individual with a disability;
3. A medical service is provided on the day that specialized transportation is billed; and
4. The service billed only represents a one-way trip.

Cost Reconciliation Process

The cost reconciliation process must be completed within twelve (12) months of the end of the reporting period covered by the annual Cost Report. The total Medicaid allowable costs based on an approved cost allocation methodology are compared to the provider's Medicaid interim payments for school based health services paid for dates of service during the reporting period as documented in the MMIS, resulting in cost reconciliation.

For the purposes of cost reconciliation, the provider may not modify the CMS- approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

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OTHER TYPES OF CARE

(d) School-Based Health Service (SBHS) Providers Continued:

Cost Settlement Process

The cost reconciliation and settlement process will be completed by June 30 of the year following the cost reporting period. DMMA shall issue a notice of settlement that denotes the amount due to or from the provider.

If a provider's interim payments exceed the actual, certified costs of the provider for school based health services to Medicaid beneficiaries, an Accounts Receivable balance will be established in the MMIS to enable the overpayment to be deducted from future claims until the AR is satisfied.

If actual certified costs of a provider for school based health services exceed the interim Medicaid claim payments, DHSS will draw the federal share for the difference and pay it to the provider in accordance with the final actual certification agreement

Special Rule for Cost Reconciliation and Cost Settlement applicable to SFYs 2009 and 2010 - Within 60 days after the end of the second quarter of time study implementation, DE will derive results from two quarters of the CMS approved time study and apply the results to the FY2009 and 2010 cost report data to determine the final reconciled costs allowable for FYs2009 and 2010. Final cost settlement of the 2009 and 2010 cost reports will be completed within 120 days from the receipt of the time study results.

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OTHER TYPES OF CARE

(d) School-Based Health Service (SBHS) Providers Continued:

Certification of Public Expenditures Process

Each LEA or school certifies on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(e) Mental Health and Drug/Alcohol Rehabilitation Services:

- Institutional - per diem
- Non-Institutional - fee-for-service or, if managed by the Department of Services for Children, Youth and Their Families' Division of Child Mental Health (see ATTACHMENT 4.19-B, Page 19 Addendum).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

5. Other EPSDT Services Continued

(f) Services to Treat Autism Spectrum Disorder (ASD) Pursuant to EPSDT as defined per Attachment 3.1-A, Page 6, Addendum 1a -1g:

As available, rates are developed using the Resource Based Relative Value Scale (RBRVS) methodology. Rates are established and updated based on the RBRVS methodology as adopted by the Medicare Fee Schedule Data Base.

If no RVU exists, the agency examines the CMS-approved Medicaid fee-for-service rate schedules of other states for similar services that are comparable in program design, program structure and relative costs to Delaware's services. For those services that are substantially similar, another state's fee for the procedure may be adopted.

The agency's fee schedule rate was set as of October 1, 2016 and is effective for services provided on or after that date. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. Rates are published on the agencies website at the link below:

The fee schedule and any annual periodic adjustments to these rates are published on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Service·
5. Other EPSDT Services-(cont)

f. Assistive Technology - fee-for-service

g. Orthotics and Prosthetics - fee-for-service

h. Private Duty Nursing in excess of 8 hours per day with prior authorization - fee-for-service

i. Any other medical or remedial care provided by licensed medical providers - fee-for-service

j. Any other services as required by §6403 of OBRA '89 as it amended §1902(a)(43), 1905(a)(4)(b) and added a new §1905(r) to the Act will be reimbursed as determined be the rate setting committee

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR PHYSICAL THERAPY AND RELATED SERVICES
42 CFR 440.110

Physical therapy and related services are reimbursed as follows:

Physical and occupational therapists and speech/language pathologists who are individually enrolled with the Delaware Medical Assistance Program (DMAP) are reimbursed at a rate using Healthcare Common Procedure Coding System (HCPCS) procedure codes. Reimbursement rates shall be based on the Medicare Relative Value (RVU).

All necessary supplies and equipment used by the therapist in the course of treatment are included in the reimbursement visit and cannot be billed separately.

Services provided by an occupational therapy assistant, physical therapy assistance, and a speech/language pathology assistant are included in the reimbursement to the qualified therapist/pathologist.

Therapists that provide Hippotherapy must be certified by the American Hippotherapy Certification Board as a Hippotherapy Clinical Specialist (HCPS). Services provided during Hippotherapy are included in the reimbursement to the qualified therapist.

When billing for physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, providers shall use the appropriate Physical Medicine and Rehabilitation Current Procedural Terminology (CPT) codes and specify the diagnosis with accurate International Classification of Diseases, Clinical Modification (ICD-9-CM) codes.

When billing for services provided by a physical therapist, providers must specify the diagnosis that is being treated. For billing purposes, providers must include the medical diagnosis that may differ from the impairment-based diagnosis described in *The Guide to Physical Therapist Practice* Patient/Client Management Model.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR PHYSICAL THERAPY AND RELATED SERVICES
42 CFR 440.110 - CONTINUED

Physical therapy and related services are reimbursed as follows:

The fee schedule and any annual/periodic adjustments to the fee schedule and effective dates are available on the Delaware Medical Assistance Program (DMAP) website at:
http://www.dmap.state.de.us/downloads/feeschedules.html

The rates of service were set as of October 1, 2015 and are effective for services provided on or after that date.

Except as otherwise noted in the plan, payment for these services is based on State-developed fee schedule rates, which are the same for both governmental and private providers of freestanding inpatient rehabilitation hospital services.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
FREESTANDING BIRTH CENTER SERVICES

Medicaid providers of freestanding birth center services are reimbursed as follows:

The payment for services provided by a freestanding birth center is limited to the lower of the billed amount or the State fee schedule amount based on a revenue code. Revenue codes as identified by Medicaid have associated flat facility rates which determine the appropriate payment for the service billed by the center. The agency's fee schedule for freestanding birth center services was established in 1993 and is effective for services provided on or after that date. All government and private providers are paid according to the same methodology. The fee schedule will be published on the DMAP website at:
http://www.dmap.state.de.us/downloads.html

Physicians, midwives, and other licensed practitioners as defined per Attachment 3.1-A, Page 11, are paid a separate fee for services performed in the freestanding birth center based on procedure code and as specified in Attachment 419-B, Other Types of Care. All government and private providers are paid according to the same methodology. The fee schedule will be published on the DMAP website at: http://www.dmap.state.de.us/downloads.html

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

18. Hospice Care

Reimbursement for Hospice care will be made at one of four predetermined rates for each day in which a beneficiary is under the care of the Hospice. The daily rate (and hourly rate for Continuous Home Care) is applicable to the type and intensity of services furnished to the beneficiary for that day. There are four levels of care into which each day of care is classified:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

The Centers for Medicare and Medicaid Services (CMS) computes a set of prospective Medicaid hospice rates based on the methodology used in setting Medicare hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Medicaid hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register. In no case may hospice payment amounts be established in amounts lower than the Medicaid hospice amounts computed by CMS. The Medicare reimbursement cap will not be applied to Delaware Medicaid hospice providers.

Payment for Room and Board in a NF or ICF/MR - For Medicaid beneficiaries who elect to receive hospice care while residing in a nursing facility or ICF/MR facility, in addition to the payment for routine care or continuous care referenced above, the hospice provider will also be reimbursed a per diem amount to cover room and board services provided by the nursing facility or ICF/MR facility. This reimbursement rate is equal to 95 percent of the base rate that would have been paid to the facility under Delaware Medicaid policy.

Payment for Physician Services - The hospice must bill for physician services rendered to a hospice patient for a diagnosis related to the terminal illness when a physician employee of the hospice (including volunteering physicians) is performing direct care services as an attending physician or when the attending physician requests medically necessary services be provided by another doctor. This payment is in addition to the four prospective rates above paid to the hospice. When billing the Delaware Medical Assistance Program (DMAP) for these physician services, the hospice must use the procedure code that reflects what the physician would have billed the DMAP had (s)he been able to bill directly in conjunction with the appropriate revenue code. DMAP will pay the claim based on its physician fee schedule. If the attending physician is not a hospice employee, the physician will bill Delaware Medicaid directly and payment will be made to the physician as per the Delaware Medicaid physician fee schedule.

Hospice payment rates can be found on the Delaware Medical Assistance Program website at: http://www.dmap.state.de.us/downloads.html. The fee schedule on the website includes all annual or periodic adjustments. Except as otherwise noted in the plan, the hospice fee schedule is the same for both governmental and private providers.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES (Continued)

Payment for the telehealth originating site facility fee is made at the same percentage of the Medicare rate that is used for practitioner services on the date of service. The State currently pays practitioners at 98% of Medicare rates. The originating site fee will also be paid at 98% of the Medicare fee for the same service.

The site fee is only for the originating site and the site provider would not be entitled to any other payment for the telemedicine service which was delivered by the distant site.

Qualifying provider services include office visits, consultations, psychotherapy, medication management, psychiatric interview or examination, substance abuse screening and brief intervention, neurobehavioral examination, end stage renal disease services and medical nutrition therapy, etc.

Federally Qualified Health Centers and School-Based Wellness Centers acting in the role of an originating site provider with no other separately identifiable service being provided will only be paid the originating site telehealth fees and will not receive reimbursement for an encounter.

The telemedicine payment methodology shall be effective with dates of service on or after January 1, 2020.

Fee schedules for telemedicine provided services are available on the DMAP website at: https://medicaid.dhss.delaware.gov/provider.

Except as otherwise noted in the Medicaid State Plan, State-developed fee schedule rates are the same for both government and private providers.

Separate reimbursement is not made for the use of technological equipment and systems associated with a telemedicine application to render the service.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES (Continued)

28. CHIROPRACTIC SERVICES

Chiropractic services and qualified providers are defined per Attachment 3.1-A, Page 3 Addendum.

The reimbursement methodology is a "fee schedule" methodology. Under the fee schedule methodology, reimbursement services for chiropractic services is made at the lower of the provider's billed charge for the services, the Resource Based Relative Value Scale (RBRVS) methodology used for physicians (which Delaware Medicaid currently pays at 98% of the Medicare rate), or the maximum allowable fee for chiropractic services under the Delaware Medicaid provider reimbursement fee schedule. The reimbursement rates are effective for dates of service on or after April 1, 2014.

Fee schedules for chiropractic services are available on the Delaware Medical Assistance Program (DMAP) website at http://www.dmap.state.de.us/downloads/feeschedules.html.

Except as otherwise noted in the Medicaid State Plan, State-developed fee schedule rates are the same for both governmental and private providers.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For Targeted Case Management services for Individuals Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family's Home

Monthly Rate:

Targeted case management for Individuals Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family's Home will be reimbursed at a unit cost rate. The initial rate will be established using reasonable estimates for the following costs based on OMB Uniform Guidance on Cost Principals:

- Practitioner salary, consistent with the minimum state case manager qualifications for this service.
- Employment Related Expenses including fringe benefits and taxes, paid time off and training.
- Program Indirect Expenses necessary for the provision of TCM services including supervision, technology, quality assurance and allowance for non-productive time.
- Practitioner Transportation costs (not to include transportation of consumers).
- General and Administrative Cost necessary for the provision of TCM services limited to 12 %.

Statistically valid time study data is used to determine the proportion of total cost that represents a Medicaid allowable activity.

Total allowable cost is divided by the units of service to compute a unit cost rate.

After the initial rate is established using a negotiated TCM budget, an annual CMS-approved cost report will be completed by the provider each year for the period July 1 – June 30 and will be used by the state to compute each subsequent annual rate. The cost report is due 45 days after the end of the reporting period.

Each year a carry forward adjustment will be made to the next year's provisional rate to account for differences between projected and actual cost for the rate period. The carry forward adjustment computation will be performed within three months of the receipt of the cost report.

A unit of service shall:
(a) Be one (1) month; and
(b) Consist of a minimum of one (1) service contact that can include face-to-face, telephone or email contacts with the recipient or on behalf of the recipient.

Claim edits will be created to ensure that only one TCM claim is paid per month for a Medicaid recipient in one of the target groups A or B as identified in the SPA.

The fee schedule rate was set as of 4/1/2017 and is effective for service provided on or after that date.

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For Targeted Case Management services for Individuals with Intellectual and Developmental Disabilities Approved for Funding through the Delaware DDDS HCBS Waiver Program DE 0009 Who Are Authorized to Receive Residential Habilitation

Monthly Rate:
Targeted case management for Individuals Approved for Funding through the Delaware DDDS HCBS Waiver Program DE 0009 Who Are Receiving Residential Habilitation will be reimbursed at a unit cost rate. This rate will be established using an annual cost report for the period July 1 through June 30 that uses OMB Uniform Guidance on Cost Principals and that captures costs for the following cost categories:

- Practitioner salary meeting the qualifications specified in Attachment 3.1-A.
- Employment Related Expenses including fringe benefits and taxes, paid time off and training.
- Program Indirect Expenses necessary for the provision of TCM services including supervision, technology, quality assurance and allowance for non-productive time.
- Practitioner Transportation costs (not to include transportation of consumers).
- General and Administrative Cost necessary for the provision of TCM services per the federally approved indirect cost rate.

Statistically valid time study data is used to determine the proportion of total cost that represents a Medicaid allowable activity.

Total allowable cost is divided by the units of service to compute a unit cost rate.

The initial rate will be established using cost data for the period July 1, 2015 through June 30, 2016, using a CMS-approved cost report, the percentage of reimbursable activity from the 100% time tracking results for the period July 1, 2015 through June 30, 2016 and billable units. Each year thereafter, a carry forward adjustment will be made to the next year's provisional rate to account for differences between projected and actual cost for the rate period. The carry forward adjustment computation will be performed within three months of the receipt of the cost report. The cost report is due 45 days after the end of the reporting period.

A unit of service shall:
(a) Be one (1) month; and
(b) Consist of a minimum of one (1) service contact that can include face-to-face, telephone or email contacts with the recipient or on behalf of the recipient.

Claims will be processed in the MMIS. Pre-payment edits will be created to ensure that only one claim will be paid for each month.

The fee schedule rate was set as of 12/31/16 and is effective for services provided on or after 1/1/2017.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Children and Youth with Serious Emotional Disturbance, or Co-occurring Mental Health and Substance Use Disorders meeting DPBHS Eligibility Criteria

Reimbursements for services are based upon a Medicaid fee schedule established by the Delaware Medical Assistance Program (DMAP).

The fee development methodology built fees considering each component of provider costs as outlined below. These reimbursement methodologies produced rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule is equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development:

- Staffing Assumptions and Staff Wages;
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)**;**
- Program-Related Expenses (e.g., supplies)**;**
- Practice model standards *(Compensation, supervision, materials and supplies, travel, training, administration, and utilization);*
- Provider Overhead Expenses; and
- Program Billable Units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units. A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations.
The Agency's fee schedule rate was set as of April 1, 2018 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at http://www.dmap.state.de.us/downloads/feeschedules.html.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this state plan), if applicable, the Medicaid agency uses the following general method for payment:

☒ 1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".**

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item _____ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR. "

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item _____ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item _____ of this attachment (see 3. above).

**SP- All groups and payments.

*Information previously on Attachment 4.19-B (no supplement or page number)
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs	Part A	SP	Deductible	SP	Coinsurance
	Part B	SP	Deductible	SP	Coinsurance
Other Medicaid Recipients	Part A	SP	Deductible	SP	Coinsurance
	Part B	SP	Deductible	SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP	Deductible	SP	Coinsurance
	Part B	SP	Deductible	SP	Coinsurance

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Payment of Medicare Part A and Part B Deductible/Coinsurance

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Standards for Payment of Reserved Beds During Absence from Long-Term Care Facilities
42 CFR 447.40

Payment will be made for reserving beds in long-term care (LTC) facilities for recipients during their temporary absence for the following purposes:

1. Hospitalization for acute conditions:

   a. For periods of hospitalization for acute conditions up to fourteen (14) days per hospitalization in any thirty-day period for individuals residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

   b. For periods of hospitalization for acute conditions up to seven (7) days per hospitalization in a thirty-day period for individuals residing in all other LTC facilities.

2. For leaves of absence up to eighteen (18) days per calendar year as provided for in the recipient's plan of care.

3. If a recipient's physical condition is being negatively impacted by his or her emotional need to be in a family setting, prior approval may be obtained for a waiver of the eighteen-day leave of absence limitation (for other than acute care hospitalization) from the Title XIX Medical Consultant in order to allow the patient more time to visit with his or her family, as long as such absences are provided for in the recipient's written plan of care.

   To obtain approval, a written request must be submitted by the long-term care facility to the Long-Term Care Coordinator and must include:

   a. Reason for the request;
   b. Medical summary;
   c. Statement from the LTC facility's medical director regarding the medical necessity of the patient being absent from the facility in excess of eighteen (18) days per year;
   d. Anticipated frequency of absence; and
   e. Number of days the recipient was absent from the LTC facility during the previous six-month period.

   The number of days waived must fall within a six-month period.

   Any request for a waiver after the six-month limit must be resubmitted and approved for payment to be continued.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM FOR LONG TERM CARE FACILITIES

A. (1). Notwithstanding any other provision of this section, the following adjustments will apply to reimbursement rates for all long term, care facilities.

(2). Effective for dates of service on or after April 1, 2009, per diem rates for long term care facilities with the exception of state owned and operated facilities, will be adjusted to the rates that were in effect on December 31, 2008.

(3) With specific regard to non-public facilities reimbursed under the payment methodologies in Section III.3 (ICF/MR facilities) of this Attachment, effective for dates of service on or after August 1, 2012, per diem rates shall not be subject to the provision of paragraph A.(2) of this section and shall be computed as described in Section III of this Attachment.

(4) With specific regard to nursing facilities reimbursed under the payment methodologies in Sections II and IX of this Attachment, if Delaware has in effect a nursing facility quality assessment fee applicable to assessment periods beginning on June 1, 2012 and thereafter, the per diem rates computed in accordance with paragraph A.(2) of this section shall be increased by a Quality Assessment Rate Adjustment Amount as described in paragraph B of this section.

B. Except as excluded in paragraph B.(c) of this section, each nursing facility's rates shall be increased for dates of service beginning on or after June 1, 2012 by a per day dollar amount equal to the sum of:

(a) a per day dollar amount equal to the per day dollar amount of the Nursing Facility Quality Assessment fee that will be owed for the upcoming rate year by each facility as specified in Delaware Code Title 30, Chapter 65 section 6502 (b) and (d), plus

(b) a per day dollar amount computed as follows:

Step 1. Obtain the total annual Medicaid patient days for all participating nursing facilities from the Delaware Medicaid nursing facility cost reports for the fiscal year ending June 30 of the previous year for each facility, excluding government-operated and pediatric nursing facilities. Sum the Medicaid patient days for each facility to compute the total aggregate statewide Medicaid patient days.

Step 2. For each facility identified in Step #1, multiply the per day dollar amount of the Nursing Facility Quality Assessment Fee that will be owed per paragraph B. (a) above by each facility times the number of Medicaid patient days for each facility from Step #1. Sum the dollar amounts for all facilities to compute the aggregate statewide total annual assessment amount to be paid to the facilities.

Step 3. Obtain the Total annual patient days and non-Medicare patient days for the fiscal year specified in Step 1 from each of the facilities that will be subjected to the quality assessment specified in paragraph (a) above for the upcoming State fiscal year for both Medicaid and non-Medicaid nursing facilities licensed to operate in Delaware

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

Step 4. For each facility identified in Step #3, multiply the per day dollar amount of the nursing facility quality assessment fee that will be owed by each facility as specified in Delaware Code Title 30, Chapter 65 section 6502 (b) and (d) times the number of non-Medicare patient days for each facility from Step #3. Sum the dollar amounts for all facilities to compute the statewide total aggregate annual dollar amount of the assessment.

Step 5. Multiply the aggregate assessment computed in Step #4 by 0.9.

Step 6. Determine the total computable funding amount using the assessment amount from Step 5 as the state share at the applicable FMAP (and any other allowable Federal match) for the payment period.

Step 7. Subtract the Medicaid portion of the assessment computed in Step #2 from the total computable payment amount computed in step #6.

Step 8. Divide the dollar amount computed in step #7, by the statewide aggregate patient days from Step #1 to compute a per day dollar amount to be added to (a) above.

(c) The following Long Term Care nursing facilities are excluded from the quality assessment rate adjustment amounts computed in (a) and (b) above:

- government-owned nursing facilities,
- facilities that exclusively serve children,
- facilities with no Medicaid patients,
- facilities that are subject to penalties under Delaware Code Title 30, Chapter 65 section 6503 for dates of service in the months that penalties apply,
- facilities not located within the State of Delaware,
- all nursing facilities are excluded from this Quality Assessment Rate Adjustment Amount if the State of Delaware does not implement or if implemented, subsequently terminates, a nursing facility quality assessment fee

C. Future rate adjustments will be suspended until further notice.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

I. General Provisions

A. Purpose

This plan establishes a reimbursement system for long-term care facilities that complies with federal requirements, including but not limited to:

- Requirements of the Omnibus Reconciliation Act of 1981 that nursing facility provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility.
- The requirement that Medicaid payments in the aggregate do not exceed what would have been paid by Medicare based on allowable cost principles.
- Limitations on the revaluation of assets subsequent to a change of ownership since July 18, 1984.
- Requirements of the Omnibus Reconciliation Act of 1987 to establish one level of nursing care, i.e., Nursing Facility Care, to eliminate the designation of Skilled and Intermediate Care, and to provide sufficient staff to meet these requirements.
- The requirement to employ only nurse aides who have successfully completed a training and competency evaluation program or a competency evaluation program.

B. Reimbursement Principles

1. Providers of nursing facility care shall be reimbursed prospectively determined per diem rates based on a patient based classification system. Providers of ICF-MR and ICF-IMD services shall be reimbursed prospectively determined per diem rates.

2. The Delaware Medicaid Program shall reimburse qualified provides of long-term care based on the individual Medicaid recipient's days of care multiplied by the applicable per diem for that patient's classification less any payments made by recipients or third parties.

II. Rate Determinations for Nursing Facilities

A. Basis for Reimbursement

Per diem reimbursement for nursing facility services shall be composed of five prospectively determined rate components that reimburse providers for primary patient care, secondary patient care, support services, administration, and capitol cost.

The primary patient care comment of the per diem rate is based on the nursing care cost related specifically to each patient's classification. In addition to assignment to case mix classifications, patients may qualify for supplementary primary care reimbursement based on their characteristics and special service needs. Primary care components reimbursement for each basic patient classification will be the same for each facility within a group. For the purpose of establishing rates, nursing facilities shall be divided into groups of like facilities for which a schedule of primary rates, including rate additions, is established for each group:

Peer Group A	Private facilities in New Castle County
Peer Group B	Private facilities in Kent and Sussex Counties and the Delaware Veterans Home operated by the Delaware Department of State
Peer Group C	Public facilities operated by the Delaware Department of Health and Social Services

Payment for the secondary, support, administrative, and capitol cost comprise the base rate, and is unique to each facility. Provider cost are reported annually to Medicaid and are used to establish rate ceilings for the secondary, support, and administrative cost centers in each provider group.

The sections that follow provide specific details in rate computation for each of the five rate components.

B. Rate Components

Payment for services based on the sum of five rate components. The rate components are defined as:

- **Primary Patient Care.** This cost center encompasses all cost that are involved in the provision of basic nursing home patients as is inclusive of nursing staff salaries, fringe benefits, and training cost. All nurses' salaries, fringe benefits, and training for staff with duties that count towards the minimum staff requirements will be included in this cost center.

- **Secondary Patient Care.** This cost center encompasses other patient care cost that directly affect patient health status and quality of care and is inclusive of clinical consultants, social services, raw food, medical supplies, and non prescription drugs, dietitians services (in public facilities only), and activities personnel.

- **Support Services.** This cost includes cost for departments that provide supportive services other than medical care and is inclusive of dietary, operation and maintenance of the facility, housekeeping, laundry and linen, and patient recreation.

- **Administration.** This category includes cost that are not patient related and *is* inclusive of owner/administrator salary, medical and nursing director salary (excluding such time spent in direct patient care), administrative salaries, medical records, working capital, benefits associated with administrative personal, home office expenses, management of resident personal funds, and monitoring and resolving patient's rights issues.

- **Capitol**. This category includes costs related to the purchase and lease of property, plant and equipment and is inclusive of lease cost, mortgage interest, property taxes and depreciation.

Expenditures for the Delaware Veterans Home in the cost categories identified above are funded through appropriations via the Delaware Department of State which is responsible for the day to day operations of the Veterans Home. Expenditures are recorded at the state level based on Veterans Home invoices recorded by state level controllers for inclusion on the appropriate CMS draw down and expenditure reports.

C. Excluded Services

Those services to residents of private long term care facilities that are ordinarily billed directly by practitioners will continue to be billed separately and are not covered by the rate component categories. This includes prescription drugs, Medicare Part B covered services, physician services, hospitalization and dental services, laboratory, radiology, and certain ancillary therapies.

For public facilities, laboratory, radiology, prescription drugs, physician services, dental services, and ancillary therapies may be included in the per diem.

Cost of training and certification of nurse aides are billed separately by the facilities as they are incurred, and are reimbursed directly by Medicaid.

D. Primarily Payment Component Computations

The primary patient care rate component is based on a patient index system in which all nursing home patients are classified into patient classes. The lowest resource intensive clients are placed in the lowest class.

The Department will assign classes to nursing home patients. Initial classification of patients occurs through the State's pre-admission screening program. These initial classifications will be reviewed by Department nurses within 31 to 45 days after assignment. Patient classification will then be reviewed at least twice a year. Facilities will receive notices from the Department concerning class changes and relevant effective dates.

1. In order to establish the patient classification for reimbursement, patients are evaluated and scored by Medicaid review nurses according to the specific amount of staff assistance needed in Activity of Daily Living (ADL) dependency areas. These include Eating, Mobility, Transfer, and Toileting. Potential scores are as follows:

   0 - Independent
   1 - Supervision (includes verbal cuing and occasional staff standby)
   2 - Moderate assistance (requires staff standby/physical presence)
   3 - Maximum Assistance

   Patients receiving moderate or maximum assistance will be considered "dependent" in that ADL area. Patients receiving supervision will not be considered dependent. Reimbursement is determined by assigning the patient to a patient classification based on their ADL scores and the provision of any Clinical Care Items.

   Each patient classification is related to specific nursing time factors. These time factors are multiplied by the 75th percentile nurse wage in each provider group to determine the per diem rate for each classification.

2. Patients receiving an active rehabilitative/preventive program as defined and approved by the Department shall be reimbursed an additional 20% of the primary care rate component.

To be considered for the added reimbursement allowed under this provision. A facility must develop and prepare and individual rehabilitative/preventative care plan. This plan of care must contain rehabilitative/preventative care programs as described in a Department approved list of programs. The services must seek to address specific activity of daily living and other functional problems of the patient. The care plan must also indicate specific patient goals and must have a physician's approval.

The Department will evaluate new facility-developed rehabilitative/preventive care plans during its patient classification reviews of nursing homes.

Interim provisional approval of plans can be provided by Department review nurses. When reviewed, the Department will examine facility documentation on the provision of rehabilitative/preventive services to patients with previously approved care plans as well as progress towards patient goals.

3. Patients exhibiting disruptive psychosocial behaviors on a frequent basis as defined and classified by the Department shall receive an additional 10 percent of the primary care rate component for the appropriate classification.

   The specific psychosocial behaviors that will be considered for added reimbursement under this provision are those that necessitate additional nursing staff intervention in the provision of personal and nursing care. Such behaviors include: verbal and physically disruptive actions, inappropriate social behavior, non-territorial wandering, and any other similar patient problems as designated by the Department.

   Facilities must have complete documentation on frequency of such behaviors in a patient's chart for the Department to consider the facility for added reimbursement under this provision. This documentation will be evaluated during patient classification reviews of a nursing home.

4. Patient class rates are determined based on the time required to care for patients in each classification, and nursing wage, fringe benefit, and training costs tabulated separately for each facility peer group.

   Primary rates are established by the following methodology:

   - Annual wage surveys and cost reports required of each provider are used to determine 75th percentile hourly nursing wages for Peer Groups A and B. For

Peer Group C, wage surveys and cost reports are combined and treated as one facility prior to determining the 75th percentile.

The cost report used in the calculations will represent the fiscal year ending June 30th of the previous reimbursement year. The Delaware reimbursement year, for purposes of rate setting, is from January 1 through December 31 for Peer Groups A and B, and October 1 through September 30 for Peer Group C.

This is calculated by first dividing total pay by total hours for each nursing classification (RN, LPN, Aide) in each facility, then arraying them to determine the 75th percentile within each provider group. Based on cost data from each provider group, hourly wage rates are adjusted to include hourly training and fringe benefit costs within each provider group.

- In each of the provider peer groups, the rates are established in the same manner.

  The primary component of the Medicaid nursing home rate is determined by multiplying the 75th percentile hourly nursing wage for RNs, LPNs, and Aides by standard nursing time factors for each of the base levels of patient acuity.

- Providers will be reimbursed for agency nurse costs if their use of agency nurses does not exceed the allowable agency nurse cap determined each year by the Delaware Medicaid staff. Any nursing cost incurred in excess of the allowable cap will not be included in the nursing cost calculation.

- Within each of the patient classes, Medicaid provides "Incentive add-ons" to encourage rehabilitative and preventive programs. Rehabilitative and preventive services shall be reimbursed an additional 20% of the primary care rate component. Incentive payments discourage the deterioration of patients into higher classifications.

- Patients who exhibit disruptive psychosocial behaviors on a frequent basis, as defined by the Department, and who receive an active psychosocial/preventive program, as defined and approved by the Department, shall be reimbursed an additional 10% of the primary care rate component.

- Patients receiving an active rehabilitative/preventive program in addition to a psychosocial/preventive program as defined by the Department, shall be reimbursed an additional 32% of the primary care rate component (20% for the rehabilitative program plus 10% for the psychosocial rate enhancement on top of the 20%).

E. Non-primary Rate Component Computations

Facility rates for the four non-primary components of secondary, support, administrative, and capital are computed from annual provider cost report data on reimbursable costs. Reimbursable costs are defined to be those that are allowable based on Medicare principles, according to HIM 15. Costs applicable to services, facilities, and supplies furnished to a provider by commonly owned, controlled or related organizations shall not exceed the lower cost of comparable services purchased elsewhere.

The cost report used in the calculations will represent the fiscal year ending June 30th of the previous reimbursement year. The Delaware reimbursement year, for purposes of rate setting is from January 1 through December 31 for Peer Groups A and B and October 1 through September 30 for Peer Group C.

- Individual allowable cost items from cost reports for each facility comprising the base rate component are summed and divided by patient days. For established facilities, the patient day amount used in this computation equal actual patient days or estimated days based on a 90 percent occupancy of Medicaid certified beds, whichever is greater. The day amount for new facilities* equals actual patient days for the period of operation, or estimated days based on a 75 percent occupancy of Medicaid certified beds, whichever is greater. This applies to cost centers comprising the basic rate.

The discussion that follows explains rate computation for the secondary, support, administrative and capital payment centers.

1. Secondary patient care rates are reimbursed according to the cost of care determined prospectively up to a calculated ceiling (115 percent of median per diem costs). Using the same facility peer grouping that was determined for the calculation of the primary care payment component, the following steps are required:

   - Facilities are grouped into three peer groups – private facilities in New Castle County, private facilities and the Delaware Veterans Home in Kent and Sussex Counties, and public facilities.

- Individual allowable cost items from cost reports for each facility comprising the secondary care component are summed and divided by patient days. For established facilities, the patient day amount used in this computation equals actual patient days or estimated days based on a 90 percent occupancy of Medicaid certified beds, whichever is greater. The day amount for new facilities* equals actual patient days for the period of operation, or estimated days based on a 75 percent occupancy of Medicaid certified beds, whichever is greater.

- The median per diem cost is determined for each category of facility and inflated by 15 percent. The secondary care per diem assigned to a facility is the actual allowable cost up to a maximum of 115 percent of the median.

2. Support service component rates are determined in a manner that parallels the secondary component rate calculation process. However, the ceiling is set at 110 percent of median support costs per day for the appropriate category of facility. In addition, facilities, which maintain costs below the cap, are entitled to an incentive payment 25 percent of the difference between the facilities actual per day cost and the applicable cap, up to a maximum incentive of 5 percent of the cap amount.

   * "New facility" is defined as: (1) New construction built to provide a new service of either intermediate or skilled nursing care for which the existing facility has never before been certified, or (2) construction of an entirely new facility totally and administratively independent of an existing facility.

3. Administrative component rates are determined in a manner parallel to the secondary component. However, the ceiling is set at 105 percent of median costs per day. A facility is entitled to an incentive payment of 50 percent of the difference between its actual costs and the cap. The incentive payment is limited to 10 percent of the ceiling amount.

4. Capital component rates are determined prospectively and are subject to a rate floor and rate ceiling. The dollar amounts representing the 20th percentile of actual per diem capital cost (floor) and the 80th percentile of actual per diem capital cost (ceiling) are calculated. If the facility's costs are greater than or equal to the floor, and less than or equal to the ceiling, the facility's prospective rate is equal to its actual cost. If the facility's costs are below the floor, the prospective rate is equal to the lower of the floor or actual cost plus twenty-five percent of actual cost. If the facility's costs are greater than the ceiling, the prospective rate is equal to the higher of the ceiling or ninety-five percent of actual cost. Costs associated with revaluation of assets of a facility will not be recognized.

The capital component is also subject to the occupancy standards as set forth in section II.E. of State Plan Amendment 4.19-D. The capital component rate is calculated on a statewide basis.

5. Where services are currently contracted by the nursing facility to a practitioner, additional services may be billed directly. These services are not covered by the rate component categories for private facilities, but may be included in the rate for public facilities. These services include therapies, physician services, dental services and prescription drugs.

F. Computation of Total Rate from Components

A facility's secondary, support, administrative, and capital payments will be summed and called its basic rate. The total rate for a patient is then determined by adding the primary rate for which a patient qualifies to the facility's basic rate component. The basic payment amount will not vary across patients in a nursing home. However, the primary payment will depend on a patient's class and qualification for added rehabilitative/preventive and/or psychosocial reimbursement.

G. OBRA '87 Additional Costs

1. Nurse Aide Training and Certification

Providers of long-term care services will be reimbursed directly for the reasonable costs of training, competency testing and certification of nurse aides in compliance with the requirements of OBRA '87. The training and competency testing must be in a program approved by the Delaware Department of Health and Social Services, Division of Public Health. A "Statement of Reimbursement Cost of Nurse Aide Training" is submitted to the state by each facility quarterly.

Costs reported on the Statement of Reimbursement Cost are reimbursed directly and claimed by the State as administrative costs. They include:

- Costs incurred in testing and certifying currently employed nurse aides, i.e., testing fees, tuition, books, and training materials.

- Costs of providing State approved training or refresher training in preparation for the competency evaluation testing to employed nurse aides who have not yet received certification.

- Salaries of in-service instructors to conduct State approved training programs for the portion of their time involved with training, or fees charged by providers of a State approved training program.

- Costs of transporting nurse aides from the nursing facility to a testing or training site.

The following costs of nurse aide training are considered operational, and will be reported annually on the Medicaid cost report. These costs will be reimbursed through the Primary cost component of the per diem rate.

- Salaries of nurse aides while in training or competency evaluation.

- Costs of additional staff to replace nurse aides participating in training or competency evaluation.

- Continuing education of nurse aides following certification.

2. Additional Nurse Staff Requirements

Additional nurse staff required by a nursing facility to comply with the requirements of OBRA '87 will be reimbursed under the provisions of the Delaware Medicaid Patient Index Reimbursement System (PIRS). This system makes no distinction between levels of care for reimbursement. Nursing costs are derived from average hourly wage, benefit, and training cost data provided on the Nursing Wage Survey submitted by each facility. Prospective rates for each patient acuity classification are calculated by these costs by the minimum nursing time factors. Although representative of actual costs incurred, these prospectively determined rates are independent of the number employed or the number of staff vacancies at any given time.

3. Additional Non-Nursing Requirements

The Delaware Medicaid reimbursement system will recognize the incremental costs of additional staff and services incurred by nursing facilities to comply with the mandates of OBRA ’87. Prospective rate calculations will be adjusted to account for costs incurred on or after October 1, 1990.

Where services are currently contracted by the nursing facility to a practitioner, additional services may be billed directly. These services are not covered by the rate component categories (for private facilities, but may be included in the rate for public facilities.) These services include therapies, physician services, dental services, and prescription drugs.

A supplemental schedule to the Statement of Reimbursement Costs (Medicaid Cost Report) will be submitted by each facility to demonstrate projected staff and service costs required to comply with OBRA '87. For the rate year beginning October 1, 1990, facilities may project full year costs onto prior year reported actual costs to be included in the rate calculation.

The supplemental schedule will be used to project costs incurred for programs effective October 1, 1990 into the prospective reimbursement rates. Where nursing care facilities indicate new and anticipated staff positions, those costs will be included with the actual SFY '90 costs when calculating the reimbursement rates effective October 1, 1990.

Additional staff requirements include dietitian, medical director, medical records, activities personnel, and social worker.

H. Hold Harmless Provision

For the first year under the patient index reimbursement system the Department will have in effect a hold-harmless provision. The purpose of the provision is to give facilities an opportunity to adjust their operations to the new system. Under this provision, no facility will be paid less by Medicaid under the patient index system than it would have been paid had Federal Fiscal Year 1988 rates, adjusted by an inflation factor, been retained.

For the period October 1, 1990 to September 30, 1991, the Department will have in effect a hold-harmless provision with respect to capital reimbursement rates. The purpose of this provision is to give facilities an opportunity to adjust their operations to the new system. Under this provision, facilities will be paid the greater of the rate under the prospective capital rate methodology or the rate based on reimbursable costs. Beginning October 1, 1991, all facilities will be subject to the prospective capital rate methodology described in Section II, E.4.

I. Annual Rate Recalculation

1. Primary Payment Component

Rates for the primary patient care component will be rebased annually. Two sources of provider-supplied data will be used in this rate rebasing:

- An annual nursing wage and salary survey that the Department will conduct of all Medicaid-participating nursing facilities in Delaware.

- Nursing home cost report data on nurses' fringe benefits and training costs.

For Peer Groups A and B, the 75th percentile wages will be redetermined annually from the wage and salary survey, and the standard nurse time factors will be applied for each patient classification. The cost report and wage and salary survey will be for the previous year ending June 30. For Peer Group C, wage surveys and cost reports are combined and treated as one facility prior to determining the 75th percentile.

2. Non-Primary Payment Components

The payment caps for the secondary, support, and administrative components will be rebased every fourth year using the computation methods specified in Section E above. For the interim periods between rebasing, the payment caps will be inflated annually based on reasonable inflation estimates as published by the Department. Facility-specific payment rates for these cost centers shall then be calculated using these inflated caps and cost report data from the most recently available cost reporting period.

The capital floor and ceiling will be rebased annually.

3. Inflation Adjustment

Per diem caps for primary, secondary, support and administrative cost centers will be adjusted each year by inflation indices. The inflation indices will be obtained from a recognized source and based on an appropriate index for the primary cost center and the following cost centers: secondary, support and administrative.

The inflation factors are applied to the actual nursing wage rates to compensate for the annual inflation in nursing costs. This adjustment is made before the nurse training and benefits are added and the wages are multiplied by the standard nurse time factors.

Examples of inflation indices that may be used includes but is not limited to:

1. Department of Economics, University of Delaware Health Care Index (or other similar university research centers' index).

2. U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index.

3. CMS Prospective Payment System-Skilled Nursing Facility Input Price Index.

4. CMS Excluded Hospital 2002 Input Price Index.

5. CMS Excluded Hospital with Capital Input Price Index.

6. CMS Rehabilitation, Psychiatric, and Long Term Care Hospital with Capital Input Price Index.

Cost center caps are used to set an upper limit on the amount a provider will be reimbursed for the costs in the secondary, support, and administrative cost centers. Initially, these caps are computed by determining the median value of the provider's actual daily costs, then adjusting upwardly according to the particular cost center. The Secondary cost center cap is 115% of the provider group median, and Administrative costs are capped at 105% of the median. Delaware Medicaid will recalculate non-primary cost center caps every fourth year. The next rebase will be for rates effective January 1, 2008 for Peer Groups A and B and October 1, 2007 for Peer Group C. In interim rate years, these cost center caps will not be recomputed. Instead, cost center

caps will be adjusted by inflation factors. The inflation index provided by a recognized source will be applied to the current cap in each cost center in each provider group to establish the new cap. The actual reported costs will be compared to the cap. Facilities with costs above the cap will receive the amount of the cap.

J. Medicare Aggregate Upper Payment Limitations

The State of Delaware assures CMS that in no case shall aggregate payments made under this plan, inclusive of DEFRA capital limitations, exceed the amount that would have been paid under Medicare principles of reimbursement. As a result of a change of ownership, on or after July 18, 1984, the State will not increase payments to providers for depreciation, interest on capital and return on equity, in the aggregate, more than the amount that would be recognized under section 1861(v)(I)(0) of the Social Security Act. Average projected rates of payment shall be tested against such limitations. In the event that average payment rates exceed such limitations, rates shall be reduced for those facilities exceeding Medicare principles as applied to all nursing facilities.

III. Rate Determination ICF/MR and ICF/IMD Facilities

Delaware will recalculate the prospective per diem rates for ICF/MRs and ICF/IMDs annually for the reimbursement year, January 1 through December 31 for Peer Groups A and B and October 1 through September 30 for Peer Group C. Within Peer Groups A, B, and C defined in section II.A., there are additional classifications of facilities that affect reimbursement. They are:

1. Public ICF/MR facilities of 8 beds or less.
2. Public ICF/MR facilities of greater than 8 beds.
3. Private ICF/MR facilities of 60 beds or less.
4. Public ICF/IMD facilities.

These facilities will fall into the peer group that matches their geographic location within the state. Facilities classified as ICF/MR or ICF/IMD shall be reimbursed their actual total per diem costs determined prospectively up to a ceiling. The ceiling is set at the 75th percentile of the distribution of costs of the facilities in each class.

An inflation factor (as described in II.I.3 above) will be applied to prior year's costs to determine the current year's rate.

IV. Rate Reconsideration

A. Primary Rate Component

Long-term care providers shall have the right to request a rate reconsideration for alleged patient misclassification relating to the Department's assignment of the case mix classification. Conditions for reconsideration are specified in the Department's nursing home appeals process as specified in the long-term care provider manual.

1. Exclusions from Reconsideration

Specifically excluded from patient class reconsiderations are:

- Changes in patient status between regular patient class reviews.
- Patient classification determinations, unless the loss of revenues for a month's period of alleged misclassification equals ten percent or more of the facility's Medicaid revenues in that month.

2. Procedures for Filing

Facilities shall submit requests for reconsiderations within sixty days after patient classifications are provided to a facility. All requests shall be submitted in writing and must be accompanied by supporting documentation as required by the Department.

3. Patient Reclassifications

Any reclassification resulting from the reconsideration process will become effective on the first day of the month following such reclassification.

B. Non-Primary Rate Components

Long-term care providers shall have the right to request a rate reconsideration for any alleged Department miscalculation of one or more non-primary payment rates.
Miscalculation is defined as incorrect computation of payment rates from provider supplied data in annual cost reports.

1. Exclusions from Reconsideration

   Specifically excluded from rate consideration are:

   - Department classification of cost items into payment centers.
   - Peer-group rate ceilings.
   - Department inflation adjustments.
   - Capital floor and ceiling rate percentiles.

2. Procedures for Filing

   Rate reconsiderations shall be submitted within sixty days after payment rate schedules are provided to a facility. All requests shall be submitted in writing and must be accompanied by supporting documentation as requested by the Department.

3. Rate Adjustments

   Any rate adjustments resulting from the reconsideration process will take place on the first day of the month following such adjustment. Rate adjustments resulting from this provision will only affect the facility that had rate miscalculations. Payment ceilings and incentive amounts for other facilities in a peer group will not be altered by these adjustments.

V. Reimbursement for Super Skilled Care

A higher rate will be paid for individuals who need a greater level of skilled care than that which is currently reimbursed in Delaware nursing facilities. For patients in the Super Skilled program the rate will be determined as follows:

A summary of each individual who qualified under the Medicaid program's criteria for a "Super Skilled" level of care will be sent to local nursing facilities, which have expressed an interest in providing this level of care. They will be asked to submit bids, within a specific time frame, for their per diem charge for caring for the individual. The Medicaid program will review the bids and select the one that most meets the needs of the patient at the lowest cost.

VI. Reporting and Audit Requirements

A. Reporting

All facilities certified to participate in the Medicaid program are required to maintain cost data and submit reports on the form and in the format specified by the Department. Such reports shall be filed annually. Cost reports are due within ninety days of the close of the state fiscal year. All Medicaid participating facilities shall report allowable costs on a state fiscal year basis, which begins on July 1 and ends the following June 30. The allowable costs recognized by Delaware are those defined by Medicare principles.

In addition, all facilities are required to complete and submit an annual nursing wage survey on a form specified by the Department. All facilities must provide nursing wage data for the time periods requested on the survey form.

For patients in the Super Skilled program, annual Super Skilled bids will be considered the cost report for Super Skilled services. The nursing facility cost report must be adjusted to reflect costs associated with care for Super Skilled patients.

Failure to submit timely cost reports or nursing wage surveys within the allowed time periods when the facility has not been granted an extension by the Department, shall be grounds for suspension from the program. The Department may levy fines for failure to submit timely data as described in Section II.D. of the General Instructions to the Medicaid nursing facility cost report.

B. Audit

The Department shall conduct a field audit of participating facilities, in accordance with Federal regulation and State law**.** Both cost reports and the nursing wage surveys will be subject to audit.

Overpayments identified and documented as a result of field audit activities, or other findings made available to the Department, will be recovered. Such overpayments will be accounted for on the Quarterly Report of Expenditures as required by regulation.

Rate revisions resulting from field audit will only affect payments to those facilities that had an identified overpayment. Payment ceilings and incentive payments for other facilities within a peer group will not be altered by these revisions.

C. Desk Review

All cost reports and nursing wage surveys shall be subjected to a desk review annually. Only desk reviewed cost report and nursing wage survey data will be used to calculate rates.

VII. Reimbursement for Out-of-State Facilities

Facilities located outside of Delaware will be paid the lesser of the Medicaid reimbursement rate from the state in which they are located or the highest rate established by Delaware for comparably certified non-state operated facilities as specified above.

VIII. Reimbursement of Ancillary Service

For Peer Groups A and B:

Oxygen, physical therapy, occupational therapy, and speech therapy will be reimbursed on a fee-for-service basis. The rates for these services are determined by a survey of all enrolled facilities' costs. The costs are then arrayed and a cap set at the median rate. Facilities will be paid the lower of their cost or the cap. The cap will be recomputed every three years based on new surveys.

The Delaware Medicaid Program's nursing home rate calculation, the Patient Index Reimbursement System, complies with requirements found in the Nursing Home Reform Act and all subsequent revisions. A detailed description of the methodology and analysis used in determining the adjustment in payment amount for nursing facilities to take into account the cost of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident eligible for benefits under Title XIX is found in Attachment A.

For Peer Group C:

Ancillary Services are included in the per diem reimbursement.

IX. Reimbursement for Pediatric Nursing Facility Care

The level of reimbursement of client for clients under 21 years of age in specialized nursing facilities that serve pediatric clients will be based on one of three levels of care as determined by the DMMA Medical Evaluation Team. A per diem rate shall be established for the three levels as follows:

1. Pediatric Skilled Care – the base level
2. Advanced Pediatric Skilled Care – an enhanced level that includes increased services and costs above the base level that are necessary to meet the medical needs of children at this level
3. Advanced Pediatric Skilled Care Plus – a higher level of reimbursement than the previous level that includes increased cost of care for clients who are ventilator dependent.

Until such time as a methodology based on reported facility cost ca be developed, Pediatric Nursing Facility reimbursement shall be based on reasonable and allowable cost for comparable DMMA services that have a demonstrated cost history and that serve a similar population, adjusted as necessary to reflect the operation of a specialized inpatient facility. Rates for each level of care shall be computed annually based on prior year actual reasonable allowable cost and may be inflated as described in Section II.I.3. Such rates shall be prospective and final and not subject to cost settlement. In addition to all nursing and operational costs, per diem rates are inclusive of all services, including but not limited to all therapies, supplies, non-custom durable medical equipment and over-the-counter (OTC) drugs required to treat the child's medical condition but to not include custom durable medical equipment for the individual use of a client or prescription ("legend product") drugs, which may be billed directly to Medicaid by the appropriate medical care provider in accordance with Medicaid policy.

Eligible children in Pediatric Nursing Facilities located outside of Delaware are reimbursed at the rate for the Delaware Pediatric Nursing facility level of care to which they are assigned after being assessed by the DMMA Medical Evaluation Team.

As most nursing facilities are not equipped to accommodate a pediatric population with such needs, payments shall be limited in the aggregate to the amount that would be reimbursed by Medicare to a specialty children's hospital for such care.

Annual Nursing Home Assurances

In accordance with 42CFR, Part 447, Subpart C, §447.253, Delaware makes the following findings and assurances:

PAYMENT RATES

- Delaware Medicaid pays for long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations and quality and safety standards [42CFR §447.253(b)(1)(i)].

- Except for preadmission screening for individuals with mental illness and mental retardation under 42CFR §483.20(f), the methods and standards used to determine long-term care facility payment rates take into account the costs of complying with the requirements of 42CFR, Part 483, Subpart B [42CFR §447.253(b)(1)(iii)(A)].

- The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42CFR §483.30(c) to provide licensed nurses on a 24-hour basis [42CFR §447.253(b)(1)(iii)(B)].

- Delaware establishes procedures under which the data and methodology used in establishing payment rates are made available to the public [42CFR §447.253(b)(1)(iii)(C)].

- *UPPER PAYMENT LIMITS.* The proposed payment rates will not exceed the upper payment limits as specified in 42CFR §447.272 [42CFR §447.253(b)(2)].

- *CHANGES IN OWNERSHIP OF NFs AND ICFs/MR.* Delaware complies with all the requirements of 42CFR §447.253(d) in determining payments when there has been a sale or transfer of assets of a NF or ICF/MR.

- *PROVIDER APPEALS.* Delaware Medicaid provides an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates [42CFR §447.253(e)].

- *UNIFORM COST REPORTING.* Delaware Medicaid provides for the filing of uniform cost reports by each participating provider [42CFR §447.253(f)].

- *AUDIT REQUIREMENTS.* Delaware Medicaid provides for periodic audits of the financial and statistical records of participating providers [42CFR §447.253(g)].

- PUBLIC NOTICE. Delaware Medicaid determines that the public notice requirements in 42CFR §447.205 are not applicable since no changes are being made in payment methodology or rates [42CFR §447.253(h)].

Annual Nursing Home Assurances

- *RATES PAID.* Delaware Medicaid pays for long-term care services using rates determined in accordance with methods and standards specified in its approved State Plan [42CFR §447.253(i)].

RELATED INFORMATION ON

In accordance with 42CFR §447.255, Delaware submits the following information:

(a) Effective October 1, 2001 , the nursing facility weighted average per diem rate is as follows-

Statewide Private Facilities - $152.74
State-Owned Facilities - $244.16

(b) This change will have no short or long term effects on -

(1) The availability of services on a statewide basis, or
(2) The type of care furnished, or
(3) The extent of provider participation, or
(4) The degree to which costs are covered in hospitals that serve a disproportionate number of low-income patients with special needs.

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

DEFINITION OF A "CLAIM"

A request for payment from an eligible provider to the Delaware Medical Assistance Program for a covered specific unit of medical service, prescription, or supply provided to a single eligible recipient under Title XIX, either on a given date or for a specific period to services, as appropriate. All claims forms are recorded as one claim except as follows:

a) Each prescription is on claim.

b) For Medicare crossovers, each deductible/co-insurance line is one claim.

c) On invoices from practitioners, independent laboratories, special services (dental and/or transportation if used at some later date) the number of different procedures codes used on the invoice determines the number of claims.

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

Requirements for Third Party Liability (TPL)-
Identifying Liable Resources

1. Data Exchange Frequency (42 CFR 433.13.138(f)):
   a. SSA wage – quarterly
   b. IV-A agency – in Delaware is the same as the Title XIX agency and updates are available, daily
   c. State Workmen's – not Compensation files – weekly
   d. Motor vehicle – not computerized – no match available
   e. SWICA – quarterly
   f. Health Insurance Carriers – no less than once every two (2) months, unless written permission is given in advance by the agency

2. Follow-up requirements of 42 CFR 433.138 (g)(1)(i) and (g)(2)(i):

   As soon as any matches on employers are received by the Delaware Client Information System (DCIS), the system will automatically generate a letter to verify health insurance coverage. This action will be taken within 30 days of the receipt of the match data.

3. State motor vehicle match is unavailable because of the information needed for TPL is not carried in the State's motor vehicle automated system. (42 CFR 433.138(g)(3)

4. Trauma code reports are produced weekly by the fiscal agent. The TPL unit sends an accident inquiry form to the client/provider within two weeks regarding potential TPL. Positive responses result in a request for claims history and subsequent bills generated to applicable insurance company or attorney. Any information on ongoing legally liable third party resources is immediately entered into the third party database, which is part of the Medicaid Management Information System (MMIS). (42 CFR 433.138(g)(4)

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

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(A)(25)(I) of the Social Security Act.

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

Requirements for Third Party Liability -
Payment of Claims

The State's MMIS identifies liable third parties and all claims submitted for payments are processed through this system. If the provider has not compiled with TPL requirements, the claim suspends for manual review and appropriate action is taken.

The State of Delaware Title XIX Program seeks reimbursement from liable third in the following instances:

	Cost Avoidance	Post Payment Recoveries	
	Pre-payment Pended Claims	Third Party Claims for Accidental Injury	Non Accident Related Claims
Amount of money below which it is not effective to pursue a claim.	All claims where probable existence of TPL is established are cost avoided except as provided for in the TPL Action Plan.	$500.00	$100.00
Time limit for which reimbursement is sought.		Date of accident forward.	As accumulated over the two year period to the start of recovery proceedings.

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

Citation	Condition or Requirement
1906 of the ACT	State Method on Cost Effectiveness of Employer-Based Group Health Plans

SEE ATTACHMENT 4.22-C, Pages 2 and 3

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

State Method on Cost Effectiveness of Employer-Based Group Health Plans

The Delaware Medicaid Program intends to review every Medicaid applicant or recipient who is eligible for enrollment in an employer-based group health plan [as defined in accordance with Section 1906(e)(1) of the Social Security Act and §5000(b)(1) of the Internal Revenue Code of 1986]. The review will target cost effectiveness. An individual's enrollment in a group health plan will be determined to be cost effective if all costs associated with the group health plan (premiums, deductibles, co-insurance, other cost sharing obligations, and administrative costs as allowed by Section 3910.11 of the State Medicaid Manual as revised 04/91) is less than the Medicaid payment for a set of services equivalent to those covered by the specific group plan.

Delaware's cost effectiveness variables include, but are not limited to

1. Cost of premium
2. Amount of deductible and co-insurance
3. Covered services
4. Age and sex of case members
5. Family size
6. Category of assistance

The above information is gathered and evaluated in the following manner:

1. Health Insurance Policy Information - Will be gathered at intake and redetermination intervals from information on the group health plan(s) available to the recipient. The needed information will include the effective date of the policy, benefits and exclusions of the plan, premium amounts, and general rates of payment, deductibles, and co-pay amounts.

2. Recipient Information - Staff will obtain information on each recipient on the case, including, but not limited to: age, sex, county, and aid category.

3. Average Medicaid Costs - For cases in which a claims payment history is established for the recipient, the average Medicaid cost will be determined based on the most recent year's expenditures. For cases in which an actual claims payment history is unavailable, MMIS data will be used to create an annual profile of estimated yearly costs for persons similar to the recipient based on age, sex, and county and aid category.

4. Medicaid Costs for Included Services - Medicaid will determine what percentage of Medicaid expenditures would be covered under the group health plan based on the covered services of the plan. This will be done by assigning percentages to the dollars spent by Medicaid on the following services (taken from the MMIS file):
    - Inpatient Hospital
    - Outpatient Hospital (including ER)
    - Physician Medical Services (including office visits)
    - Physician Surgical Services
    - Lab & X-ray
    - Prescription Drugs
    - Maternity Care (including labor and delivery)

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

State Method on Cost Effectiveness of Employer-Based Group Health Plans

When the plan is evaluated against the above services, it will be assigned a percentage to reflect the services covered under the plan (versus what Medicaid would cover-which would be 100%). The percentage of services covered by the plan will then be multiplied by the average Medicaid costs from step 3.

5. Group Health Plan Allowable - Generally, employer plans have higher allowables for services than the Medicaid Program. To determine the amount employer-based group health plans will allow for the covered services identified in step 4, multiply the amount from step 4 by a chosen factor. This factor will be either a state specific factor, a national factor, or a group health plan specific factor.

6. Covered Expense Amount - To determine the covered expense amount (allowed amount minus coinsurance and deductibles) under the group health plan, we take the allowable amount from the above step and multiply it by an average group health plan payment rate. The group health plan payment rate will be based on a state specific factor, a national factor, or a group health plan specific factor.

7. Administrative Costs - Administrative costs shall include, but not be limited to, the contractual costs of changes to the MMIS and to the Delaware Client Information System (DCIS) to allow for inclusion of non-recipients, tracking, making payments to and contracting with employers or insurance companies, etc., contractors needed to absorb the workload of current staff that will have to be diverted to this project and/or contractors required to develop, test and implement a PC - based system that will function in place of a DCIS/MMIS interface and tracking system, with the additional costs of hardware and software to support those systems and any additional staff needed. Administrative costs shall be reviewed annually and divided by the estimated potential number of Medicaid eligibles with employer-based group health insurance available.

8. Cost Effectiveness Determination - The final step will be determining if the group health plan is cost effective. A plan will be found to be cost effective if the total of the 3 following elements is less than the average Medicaid costs for the family:

   a) the difference between the group health plan allowable (step 5) and the covered expense (step 6)
   b) yearly premium
   c) administrative costs

If a group health plan is found to be cost effective, the clients/families will be advised of their obligation to enroll in that plan as a condition of initial or continued Medicaid eligibility. Failure to enroll in cost effective employer-based group health insurance shall **not** affect the Medicaid eligibility of any applicant/recipient who has no control over the enrollment process. The minimum enrollment period in a cost-effective group health plan will be 6 months for Delaware.

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

Citation	Sanctions for Psychiatric Hospitals
1902(y)(l), 1902 (y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, section 4755 (a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospitals deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

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

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

In accordance with the requirements of 42 CFR 435.940 through 435.960 and Section 1137 of the Act, Medicaid agency has a system for income and eligibility verification.

This Attachment describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State of Delaware has an eligibility system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States for the purpose of eligibility determination of public programs. The PARIS match helps the State maintain program integrity by detecting and deterring improper payments.

The PARIS match collects data from three separate data matches: Federal, Veterans Affairs (VA), and Interstate. The Federal match provides information about recipient's military and civil service benefits. The VA match provides information about veterans' pension and compensation benefits. The Interstate provides information about recipients' possible receipt of duplicative TANF, Medicaid, and Food Benefits issued by the 50 states, Washington, D.C., and Puerto Rico.

The information that is requested will be exchanged with other States and entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

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

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Delaware residents who are homeless may use the address of the Division of Economic Services and pick up their Medicaid card at the nearest DES office.

The applicant/recipient is informed at the time of their application, or at the time that they report that they are homeless, where and when they may pick their check and/or Medicaid card. They must pick up the card in person and are informed of the day and time the cards are available.

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

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and state forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Information begins on Attachment 4.34-A, Page 1a Addendum

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

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

The Death with Dignity Law (Title 16, Chapter 25 of the Delaware Code) authorizes a living will to direct that ''maintenance medical treatment" be withheld or withdrawn.

DEFINITIONS:
Terminally Ill- Any disease, illness, or condition from which there is no reasonable medical expectation of recovery and which, as a medical probability, will result in death regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life.

Maintenance Medical Treatment- Any medical or surgical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a, vital function; and which would serve only to artificially prolong the dying process. The "maintenance medical treatment" shall not include the administration of medication, nor the performance of any medical procedure necessary to provide comfort care or to alleviate pain.

Artificial Means- Manufactured or technical contrivances which may be attached to or integrated into the human body, but which are not a part of the human body.

In Delaware, there have been no court cases or legislative directives to clarify which procedures would definitely be included within the meaning of "maintenance medical treatment'. Medication and comfort-care measures are not considered to be "maintenance medical treatment".

The definition of durable powers of attorney is located in Title 12 of the Delaware Code, Chapter 49, Section 4901.

There is no expressed provision identifying whether the State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

The official statement of Delaware's law on advance directives, prepared by Delaware's Committee on the Patient Self-Determination Act and adopted by the State's Board of Health, begins on Attachment 4.34-A, Page 1b Addendum.

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

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

YOUR RIGHTS TO DECIDE ABOUT YOUR HEALTH CARE

WHO DECIDES WHAT HEALTH CARE I GET?

As a competent adult, you have the legal right to make your own health care decisions. Your doctor or another health care professional may advise you and make recommendations about treatment. You have the right to receive this information in a way you can understand. You have the authority to say "yes" to any treatment that is offered to you, and to say "no" to any treatment that you don't want.

WHAT IF MY MEDICAL CONDITION MAKES ME UNABLE TO DECIDE?

In Delaware, if you are at least 18 years old you may make a written "advance directive" to accept or refuse most health care treatments or procedures. Your advance directive will tell your doctor what you want if you become unable to decide yourself. Under Delaware law you may use any of three advance directives: 1) A Living Will, 2) An appointment of a Health Care Agent, or 3) A Durable Power of Attorney for Health Care.

WHAT IS A LIVING WILL?

A Living Will is a written statement of your wishes about the use of life sustaining procedures if you are in a terminal condition. You are in a terminal condition if your condition will result in your death. You may not be in a terminal condition if you are in a persistent vegetative state. Two doctors must state in writing that you are in a terminal condition. You may state in your Living Will that, if you are in a terminal condition, you do not want any procedures that will artificially prolong the dying process.

If you want a Living Will, you must make it while you are still capable and competent to make health care decisions. **Two witnesses who are at least eighteen years old must watch you sign. You must choose witnesses who are not members of your family, will not inherit** anything from you when you die, and do not have to pay for your care. If you are in a hospital, nursing home or similar facility when you sign your Living Will, you must choose witnesses who are not employees of the facility. In addition, if you are in a nursing home or similar facility, one of the witnesses must be a Long Term Care Ombudsman or the Public Guardian.

CAN A LIVING WILL OR OTHER ADVANCE DIRECTIVE COVER ANY TREATMENT OR CONDITION?

You may wish to refuse artificially provided food or water. You may wish to refuse life sustaining treatment even though you are not in a terminal condition. You may put your wishes in writing even though Delaware law makes no specific provision for doing so in a Living Will or other advance directive. Your wishes may not be honored in all situations, but they are more likely to be followed if you state them in writing.

WHAT IS A HEALTH CARE AGENT?

Delaware law allows you to appoint another adult to be your Health Care Agent to make decisions about your health care if you become unable to decide yourself. The person you appoint has the power to make the same decisions about health care that you could make if you were able to decide yourself. Your doctor will determine when it is that you have lost the ability to decide for yourself.

You may, if you wish, specify for your agent the types of health care decisions which you want carried out for you. These can include refusing life sustaining treatment as well as other medical decisions. Examples of other medical decisions are to consent to or refuse surgery or tests, or to get your medical records. However, you don't have to instruct your Health Care Agent in any particular way if you choose not to.

You must appoint your Health Care Agent in writing. You must sign the document and it should be witnessed in the same way as a Living Will.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

Another Delaware law allows you to have a document naming an adult to make health care decisions for you. This person must follow any instructions you give in the document.

You may include a Durable Power of Attorney for Health Care in a general durable power of attorney which would allow the person making decisions for you to act for you in virtually all matters - legal, personal and financial. You may also make a Durable Power of Attorney for Health Care a "stand alone document. In either case, the document must be signed and should be witnessed in the same way as the other advance directives discussed here.

WHERE SHOULD I KEEP MY ADVANCE DIRECTIVE?

You should keep the original and give copies to family members, and to your doctor and other health care providers. It will become a part of your medical records. If you want, you can also give copies to close friends, your lawyer or your clergyman.

WHAT IF I CHANGE MY MIND?

You can revoke your advance directive at any time by destroying it, by making a new one, or by telling two people at the same time that you no longer wish your advance directive to be effective. You should also, in writing, inform your doctor or other health care provider and any health care agent you may have named of your decision to revoke.

WILL MY ADVANCE DIRECTIVE BE VALID IN ANOTHER STATE?

State laws vary considerably on advance directives. While the advance directive you make in one state may be good in another state, there is no guarantee of that. If you move to another state, you should make a new advance directive in that state.

WHAT HAPPENS IF I MAKE NO ADVANCE DIRECTIVE?

You don't have to make an advance directive if you don't want one. No doctor, hospital, nursing home or other health care provider can make you sign one before you get treatment. However, if you want your wishes on this subject honored, you should make an advance directive. Just telling your spouse, other family members or friends about your wishes may not be enough. Without an advance directive, a court may decide what health care you will or will not receive whenever you are unable to decide for yourself.

WHERE CAN I OBTAIN MORE INFORMATION?

If you would like more information about how to make an advance directive, about your rights to make health care decisions, or about other resources that may be able to help you, you should consult a lawyer or the Long Term Care Ombudsman at 1-800-223-9074 (New Castle County) or 1-800-292-1515 (Kent/Sussex County).

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A - no additional information beyond minimal requirements

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy	☐ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is an effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919 (h)(2)(A)) for applying the remedy.

☒ Specified Remedy	☐ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is an effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919 (h)(2)(A)) for applying the remedy.

☒ Specified Remedy	☐ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is an effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919 (h)(2)(A)) for applying the remedy.

☒ Specified Remedy	☐ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is an effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919 (h)(2)(A)) for applying the remedy.

☒ Specified Remedy	☐ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is an effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

NIA - no additional information beyond minimal requirements

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

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

In addition to full name, address, social security number, date of written and manual skills test, certification date and finding of abuse, neglect or misappropriation of property, the registry can show if the aide was deemed.

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

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

Registry has capability of providing:

Sponsors code

Test score data.

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

DEFINITION OF SPECIALIZED SERVICES

Specialized Services for PASRR

As defined in 42 CFR 483.120, Specialized Services for Preadmission Screening and Resident Review (PASRR) means services that are provided to supplement the care provided by a nursing facility under its Medicaid per diem payment that are intended to result in the continuous and aggressive implementation of an individualized plan of care for a nursing facility resident who has a mental illness or intellectual disability or developmental disability.

Mental Illness

For individuals with serious mental illness, defined in 42 CFR 483.102(b)(1), specialized services, as defined in 42 CFR 483.120(a)(1), means the services specified by the State which, combined with services provided by the nursing facility, results in the continuous and aggressive implementation of an individual plan of care that:

- Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professional and, as appropriate, other professionals,
- Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel, and
- Treatment is directed toward stabilization and restoration of the level of functioning that preceded the acute episode.

Specialized Services do not include services that can be routinely managed by a primary care provider.

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DEFINITION OF SPECIALIZED SERVICES Continued

Intellectual Disability or Developmental Disability and Related Conditions

For individuals with intellectual disability or developmental disability, defined in 42 CFR 483. 102(b)(3), specialized services, as defined in 42 CFR 483.120(a)(2), means the services that are specified by the State, which, combined with services provided by the nursing facility and other service providers results in a continuous active treatment which meets the requirements of 42 CFR 483.440(a)(1) and includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services directed toward:

- The acquisition of skills and behaviors necessary for the client to function with as much self-determination and independence as possible, and
- The prevention or deceleration of regression or loss of current optimal functional status

Specialized Services do not include services that can be routinely managed by a primary care provider.

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PASRR Level II Preadmission Screening by Categorical Determination

The following categories developed by the State mental health or intellectual/developmental disability authorities and approved by the State Medicaid Agency may be made applicable to individuals identified by PASRR Level I as possibly having serious mental illness/intellectual/developmental disability/related condition (MI/IDD/RC) when existing data on the individual appear to be current and accurate and are sufficient to allow the reviewer readily to determine that the individual fits the category. The data available includes physical, mental, and functional assessments as required by 42 CFR 483.132(c).

An adequate inspection of records for a categorical determination takes the place of the nursing facility (NF) individualized Level II evaluation and/or the Specialized Services individualized Level II evaluation as indicated below. Categorical evaluation and determination reports as required by 42 CFR 483.128 and .130, are produced, prior to admission, for all categorical determinations.

When existing data is not adequate, or any judgment is required about the presence of serious mental illness or intellectual/developmental disability, the individual is referred for individualized Level II evaluation. The State mental health or intellectual/developmental disability authority is responsible for: 1. assuring that the categorical determinations meet requirements; 2. assuring that the determinations are in the best interests of the residents; 3. retaining copies of the categorical evaluation and determination reports, and 4. maintaining a tracking system for all categorical determinations.

For time limited categories - individuals are either discharged, or evaluated by individualized Level II Resident Review, within the specified time limits. Federal Financial Participation (FFP) is not available for days of NF care after the time limit expires and before a Level II Resident Review is completed according to requirements.

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CATEGORICAL DETERMINATIONS

PASRR Level II Preadmission Screening by Categorical Determination Continued

(Check each that applies, and supply definitions and time limits as required.)

I. Categorical Determination that nursing facility (NF) placement is appropriate. (Level II Specialized Services evaluation and determination by the State Mental Health/ Intellectual Disabilities/Developmental Disabilities Authorities (SMH/ID/DDA) is individualized. A new, individualized, Level II Resident Review is required if at any time the resident demonstrates need for services related to serious mental illness, intellectual disability, developmental disability, or a related condition, or the admission exceeds the specified time limit.)

☒ **Convalescent Care:** NF services are needed for convalescent care from an acute physical illness which required hospitalization, and does not meet all the criteria for an exempt hospital discharge. (An exempt hospital discharge as specified in 42 CFR 483.106(b)(2) is not subject to Preadmission Screening, at State option.)

Definition	Time limit
No risk to self or others	
Admission directly from hospital NF for same condition can include special Medical services. Individual lacks adequate supports to safely remain in the community for the needed medical services, observation or intervention.	120 days

☒ Terminal Illness (as defined for hospice purposes at 42 CFR 418.3: a life expectancy of six (6) months or less if the illness runs its normal course). NF admission is not approved to a facility without a hospice contract unless terminal illness is documented and the individual waives a hospice contract.

Additional Definition *(optional)*
No risk to self or others

☐ Other category(s) defined by the State.

Definition	Time limit

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CATEGORICAL DETERMINATIONS

PASRR Level II Preadmission Screening by Categorical Determination Continued

II. Categorical Determination that NF placement is appropriate, and that Specialized Services are not needed. (Determination that Specialized Services are needed is individualized, not categorical.)

☒ Medical Dependence: documented severe physical illness which results in a level of impairment documented to be so severe that the individual could not be expected to benefit from Specialized Services. For example: coma, ventilator dependence, functioning at a brain stem level, or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure 42 CFR 483.130 (c)(3).

Definition
No risk to self or others

☐ Other category(s) defined by the State, in which a level of impairment is documented to be so severe that the individual could not be expected to benefit from Specialized Services.

Definition	Time limit *(optional)*

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PASRR Level II Preadmission Screening by Categorical Determination Continued

III. Provisional admissions. Categorical Determination that NF placement is appropriate for a brief period. Option to also categorically determine by the SMH/ID/DDA (not Level I screeners) that Specialized Services are not needed because stay is expected to be brief and the individual does not have a history of need for intensive MI or ID/DD services. (Determination that Specialized Services (SS) are needed is individualized, not categorical.)

☒ **Delirium:** Provisional admission pending further assessment in case of where an accurate diagnosis cannot be made until the delirium clears.

Additional Definition *(optional)*	SS Not Needed Categorical	Time limit (≤7 days)
No risk to self or others	☐	7 days

☒ **Emergency Situations:** Provisional admission pending further assessment requiring protective services, with placement in the nursing facility not to exceed seven (7) days.

Additional Definition *(optional)*	SS Not Needed Categorical	Time limit (<7 days)
No risk to self or others	☐	7 days

☒ **Respite:** Very brief and finite stays of up to a fixed number of days to provide to in-home caregivers to whom the individual with MI or ID/DD is expected to return following the brief NF stay.

Additional Definition *(optional)*	SS Not Needed Categorical	Time limit
No risk to self or others	☐	(14) days

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CATEGORICAL DETERMINATIONS

PASRR Level II Preadmission Screening by Categorical Determination Continued

IV. Categorical determination that Specialized Services are not needed. (Determination that Specialized Services are needed is individualized, not categorical. Determination by the State MH/ID/DD authority that NF placement is appropriate and is individualized.)

☒ **Dementia and Intellectual Disability/Developmental Disability (ID/DD).** The State intellectual disability authority (not Level I screeners) makes categorical determinations that an individual with dementia in combination with intellectual disability or a related condition, does not need Specialized Services. The dementia is of a severity to affect the individual's need for or ability to make use of Specialized Services.

Additional Definition *(optional)*

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

1. The state routinely sends out mass mailing letters to all providers when there are pertinent changes in current regulations, procedures and policies and for informational items.
2. The state has provided state-wide in-service programs when there is significant change in regulations.
3. Representatives of OHFLC participate in programs sponsored by other State Health Care organizations including Delaware Health Care Association, Division of Aging and others upon request to present current or changes in regulations, procedures and policies.
4. Appropriate staff from OHFLC respond to all phone and written requests for information from the health care industry and general public. Appropriate regulations, information are provided, or where they can be obtained, when applicable.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services into such a resident.

See attached - Rules and Regulations governing Delaware Patient Abuse Law

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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RULES AND REGULATIONS
GOVERNING
DELAWARE 'S PATIENT ABUSE LAW

APPROVED:

Thomas P. Eichler
THOMAS P. EICHLER, SECRETARY, DHSS.

7/17/87
DATE

SECTION I: DEFINITIONS

A. The term "Abuse" shall mean:

1. Physical abuse by intentionally and unnecessarily inflicting pain or injury to a patient or resident. This includes, but is not limited to:

   a) Striking the patient or resident by using a part of the body, such as hitting, pushing, kicking, slapping, pinching, beating, shoving, sexual molestation.

   b) Striking the patient through use of an object, such as water in a glass, a rubber band, a towel, etc.

2. Emotional abuse which includes, but is not limited to:

   a) Ridiculing or demeaning a patient or resident.

   b) Making derogatory remarks to a resident or patient.

   c) Cursing directed towards a patient or resident.

   d) Threatening to inflict physical or emotional harm on a patient or resident.

B. The term "Mistreatment" shall include the intentional, inappropriate use of medications, isolation or physical or chemical restraints on or of a patient or resident.

C. The term "Neglect" shall mean:

1. Intentional lack of attention to physical needs of the patient or resident including, but not limited to, toileting, bathing, meals and safety.

2. Intentional failure to report patient or resident health problem to an immediate supervisor or nurse.

3. Intentional failure to carry out a prescribed treatment plan for a patient or resident,

D. The term "Facility" shall include any facility required to be licensed under Chapter 11 of Title 16 of the Delaware Code. It shall also include any facility operated by or for the State which provides long-term care residential services.

E. "Patient Rights Unit" means that unit within the Division of Aging with designated investigatory powers under 16 Del. C., § 1131, et seq.

F. The term "Person" shall mean a human being and, where appropriate, a public or private corporation, an unincorporated association, a partnership, a government or government instrumentality.

SECTION II: REPORTING

A. Applicability:

1. The Patient Rights Law (16 Del. C. §1131, et seq.) applies to abuse, mistreatment or neglect of patients or residents in:

   a) Any facility required to be licensed under Chapter 11 of Title 16 of the Delaware Code.

   b) Any facility operated by or for the State which provides long-term care residential services, such as Group Homes, Foster Care Homes.

2. The statute does not apply to patient-to-patient, or third person-to-patient incidents; however, a facility in which such an incident occurs may find itself culpable if it fails to take corrective action in light of such occurrences. It is recommenced , therefore, that an investigation be conducted in those instances, but only to the extent that the facility failed to take steps to provide for the safety of its residents.

3. Nothing in the statute shall be construed to mean that a patient or resident is abused , mistreated or neglected for the sole reason he relies upon, or is being furnished with, treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, nor shall anything in this subchapter be construed to authorize or require any medical care or treatment over the implied or express objection of said patient or resident.

4. Long-term care residential facilities which serve primarily minors are covered by Delaware Child Abuse Laws. Any referrals coming from these facilities will be referred to Child Protective Services for investigation.

5. A report of suspected abuse of a minor residing in a facility covered under this statute will be referred to the Child Protective Services for joint investigation with the Patient Rights Unit.

B. Persons required to report:

1. Any employee of a facility, or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis, who has reasonable cause to believe that a patient or resident in a facility has been abused, mistreated or neglected shall immediately report such abuse, mistreatment or neglect.

   a) The person who witnesses abuse, neglect or mistreatment should be the reporting person.

b) Any person included under (1) above who fails to make a report shall be liable for a criminal fine not to exceed $1,000.

2. Any person not included under (1) above may make a report if they have reason to believe that a patient or resident of a facility has been abused, mistreated or neglected.

3. The reporting person need no more than 'suspect abuse' to report an incident.

C. How to report:

1. When an individual has information which leads him/her to believe that a patient or resident in a facility has been abused, neglected or mistreated, he/she should:

a) Immediately report that information to the Patient Rights Unit of the Division of Aging by telephone.

i) During regular office hours (Monday through Friday, 8:00 a.m. to 4:30 p.m.)the telephone number to call is:

421-6791
or 1-800-223-9074

ii) During non-office hours (evenings and weekends) the telephone number to call is:

421-6711 (New Castle Co .)
856-6626 (Kent and Sussex)
or 1-800-652-2929

b) Within 48 hours after the phone call, a written report containing all the available information must be sent to:

i) For a New Castle County facility:

Patient Rights Unit
Division of Aging
1901 N. DuPont Hwy.
New Castle, De. 19720

ii) For a facility in Kent or Sussex:

Patient Rights Unit
Division of Aging
Milford State Service Center
11/13 Church Ave.
Milford , De. 19963

iii) The requirement for a written report may be satisfied by a copy of the facility incident report, signed by the reporting person, provided that the report contains the minimum information required.

c) Any person required to make an oral and a written report who fails to do so shall be liable for a criminal fine not to exceed $1,000,

2. When failure to report comes to the attention of the Patient Rights Unit, the unit shall investigate and forward information to the Attorney General for prosecution/determination.

D. Contents of Reports:

1. When an individual makes a report of suspected abuse, mistreatment or neglect to the Patient Rights Unit, that report should include, at a minimum, the following information:

a) Name, sex, age of patient or resident allegedly being abused , neglected or mistreated.

b) Name, address and telephone number of the facility.

c) Name, address and position or relationship of the reporting individual; where, when he/she may be contacted.

d) All information about the nature and extent of the alleged abuse, neglect or mistreatment.

e) Circumstances under which the reporting person became aware of the alleged abuse, neglect or mistreatment.

f) The nature and extent of the reporting person's contact with the - resident in question.

g) Information of prior incidents of abuse, neglect, mistreatment to the resident in question, or by the suspected perpetrator to other residents.

h) Information about any corrective action taken or treatment provided to the patient or resident in question.

i) The condition and functional status of the resident in question (e.g., level of function, mobility, mental status).

j) The times and dates of witnessed incidents.

k) The identities of other witnesses of the same events.

l) Whether other residents of the same facility are being victimized.

m) Any other available information pertaining to the alleged abuse, neglect, or mistreatment.

E. Confidentiality:

1. The Patient Rights Unit will treat the identity of the reporting individual as confidential information.

2. No person making any oral or written report pursuant to this subchapter shall be liable in any civil or criminal action by reason of such report where such report was made in good faith or under the reasonable belief that such abuse, mistreatment or neglect has taken place.

3. No facility shall discharge or in any manner discriminate or retaliate against any person, by any means whatsoever, who in good faith makes or causes to be made, a report under this subchapter, or who testifies or who is about to testify in any proceeding concerning abuse, mistreatment or neglect of patients or residents in said facility.

4. Any facility which discharges, discriminates or retaliates against a person because he has reported, testified or is about to testify concerning abuse, mistreatment or neglect of patients or residents, shall be liable to such person for treble damages, costs and attorney' s fees, where a facility discharges, demotes or retaliates by any other means against a person after he made a report, testified or was subpoenaed to testify as a result of a report required under this subchapter, there shall be a rebuttable presumption that such facility discharged , demoted or retaliated against such person as a result of such report or testimony.

5. This section shall not apply to any person who has engaged in the abuse, mistreatment or neglect of a patient or resident.

F. Police Involvement:

1. The appropriate police agency must always be contacted in cases where abuse, neglect or mistreatment has resulted in death, or if the patient' s health or safety is in jeopardy from further abuse, neglect or mistreatment the Patient Rights Unit shall assure that this has been done.

2. Police should also be involved in those situations which are traditionally part of their work:

   a) In cases of serious physical injury (assault). This can be defined as physical injury which creates a substantial risk of death, or which causes serious or prolonged disfigurement, impairment of health or loss or impairment of any bodily organ.

   b) In cases of rape.

3. When conditions stated in (1) and (2)above exist, police must be contacted at the earliest possible time.

SECTION III: INVESTIGATION AND SCREENING

A. Intake and Screening:

1. Verbal reports of abuse, neglect, mistreatment of residents shall be taken by the designated Human Service Worker.
2. All information from a verbal report will be entered on a standardized intake form.
3. Screening will be done by the designated person on the investigating team .
4. Each report will be considered on an individual basis for appropriateness and urgency of response.
5. The following will be notified by the Patient Rights Unit if an investigation of reported abuse, neglect, mistreatment is to be done by that Unit:
   a) The Attorney General's Office.
   b) The Administration of the facility involved.

B. Investigation:

1. In all cases of suspected resident abuse, mistreatment or neglect reported pursuant to 16. Del. Code, §1131, et seq., the Patient Rights Unit of the Division of Aging will:
   a) Conduct its investigation of the complaint within 24 hours after receiving the oral report if there is any cause to believe that the patient's or resident's health or safety is in immediate danger from further abuse, mistreatment or neglect.
   b) Conduct its investigation of the complaint within 10 days after receiving the oral report in all other cases.
2. At a minimum, the investigation will include all of the following elements:
   a) A visit to the facility involved;
   b) A private interview with the resident allegedly abused , mistreated or neglected;
   c) Observation of resident within facility environment, if possible;
   d) An examination of the patient's or resident's medical and other records, as well as any other evidence which may be relevant to the issues involved;

e) Assessment of resident's functional level (physical and mental);

f) An examination of reports, documents, etc., prepared by the facility which relate or the incident or the facility's investigation of that incident;

g) An evaluation of the nature, extent and cause or causes of the injury or harm suffered by the patient or resident in question;

h) Interviews with any and all potential witnesses who may have information which is relevant to the issues involved who are reasonably available for such. an interview;

i) An attempt or determine the identity of the person or persons responsible for the alleged abuse, mistreatment or neglect;

j) An interview with the person or persons allegedly responsible for the suspected abuse, mistreatment or neglect, whenever their identity can be determined and an interview with them is reasonably possible; and

k) An evaluation of the environment within the facility and the risks of physical or emotional injury or harm to other patients or residents.

3. All information shall be in a written report and presented to the person(s) responsible for determination of the case.

4. The investigation by the Patient Rights Unit is a preliminary investigation of allegations and not an accusation; therefore, investigators will interview one on one without union or administrative involvement. The "rights" of the person being interviewed go into effect when the preliminary findings turn allegations into accusations, i.e., a person becomes a suspect.

5. In order to assure uniformity, the Director of the investigative team will review all investigation reports for concurrence.

C. Determination:

1. At the conclusion of its investigation, the Patient Rights Unit will prepare a final determination of whether or not sufficient credible evidence exists to sustain the allegations contained in the report.

   a. If the findings indicate that patient or resident abuse, mistreatment, or neglect has occurred and that a particular facility staff person is responsible for that abuse, mistreatment or neglect, the Division will refer the matter to the Attorney General's Office for appropriate action;

b) If the investigation reveals that a person who is required by 16 Del. Code, § 1131, et seq., to report suspected patient or resident abuse , mistreatment or neglect has failed to do so, the Patient Rights Unit will refer the matter to the Attorney General's Office for appropriate action;

c) Upon finding that abuse, mistreatment or neglect has occurred in a facility, the Unit or the Attorney General shall notify the appropriate licensing board and, if such facility receives public funding, the appropriate state or federal agency. If, after a hearing, it is determined that a member of the board of directors or a high managerial agent knew that patients or residents were abused , mistreated or neglected and failed to promptly take corrective action, the appropriate board shall suspend or revoke such facility's license;

d) If the person identified in (b) above is a licensed professional, the Patient Rights Unit will, after clearance from the Attorney General' s Office, notify the appropriate licensing board in order not to prejudice possible litigation;

e) If the findings indicate that there is a pattern of incidents of abuse between patients or residents and the facility might be deemed negligent for the subsistence of that abuse, the Division will refer the matter to the Attorney General's Office for appropriate action.

2. The Patient Rights Unit shall attempt to determine validity of the reported abuse, neglect, mistreatment; but not determine the guilt or innocence of the accused,

3. The Patient Rights Unit shall inform the Chief Administrative Officer of the facility upon the completion of the investigation.

SECTION IV: FACILITY RESPONSIBILITIES

Reporting:

A. All facilities covered under the law shall adopt and implement written policies and procedures for reporting and responding to incidents of suspected patient abuse, mistreatment or neglect. At a minimum, these policies and procedures should ensure that:

a) All incidents of suspected patient abuse, mistreatment or neglect are reported immediately to the Patient Rights Unit of the Division of Aging.

b) Any and all available information which may be relevant to a Division investigation of suspected patient abuse, mistreatment or neglect is made available to the Division upon request.

c) Reasonable efforts are made to facilitate the Division's attempts to interview any and all potential witnesses who may have information which is relevant to the issues involved in the investigation.

d) Each facility shall have a written policy regarding internal investigation procedures in reported/suspected cases of abuse, neglect, mistreatment.

e) The facility must implement their internal investigation policy concurrent with a direct immediate report to the Division for external investigation.

f) The results of the facility internal investigation shall be made available to the Patient Rights Unit during their investigation.

B. Protective Action

1. Whenever a patient or resident has suffered physical or psychological harm as a result of suspected abuse, mistreatment or neglect, a long-term care facility should immediately take any and all protective and/or remedial actions which are reasonably necessary to prevent further harm to that patient or resident and/or all other patients or residents. Such protective and/or remedial action should not be delayed solely because the Patient Rights Unit has not completed its investigation. This action should include an immediate physical examination where injury has occurred or is suspected.

2. A long-term care facility should also take reasonable and appropriate preventive and/or remedial measures to protect patients or residents from verbal abuse, intimidation or coercion by means of threats to use physical force, violations of a patient's right to be treated with dignity and respect and/or other unreasonable risks of physical or psychological harm.

C. Preventive Training:

1. In order to prevent abuse, mistreatment and neglect to the maximum extent possible, each long-term care facility shall provide regular orientation and in-service training programs for all facility personnel which emphasize the following:

a) Techniques for management of difficult patients;

b) Identification of factors which contribute to or escalate hostile behavior;

c) Assessment of personal responses to aggressive or hostile behavior;

d) Identification of employee and resident coping behaviors, and reinforcement of positive and adaptive behaviors;

e) Use of intervention techniques, including verbal responses and safe, non-injurious physical control techniques, as therapeutic tools for hostile patients;

f) Close observation of new employees during orientation;

g) Interdisciplinary program planning for patients or residents;

h) Orientation to employee responsibilities under the Patient Rights Law; including § 1131 et seq.

D. Preventive Administrative Policies:

1. In addition, in an effort to prevent patient abuse, mistreatment or neglect, long-term care facilities should adopt and implement administrative, management and personnel policies and practices which include:

a) Careful interviewing of employee applicants;

b) Close examination of applicant references prior to hiring;

c) Cooperation with other facilities in providing information about an employee's ability to handle difficult patients to prospective employers;

d) Staff support programs;

e) Close scrutiny of incident reports;

f) Careful pre-admission assessment of patients;

g) Development of patient care plans which include approaches to dealing with patients who may provoke hostile behavior by staff members or fellow patients;

h) Provision of relevant information regarding difficult or emotionally unstable patients, and approaches to be used in caring for them on a systematic basis;

i) Distribution of Patient Rights brochures to staff;

j) Make Patient Rights brochures available to patients, residents, guests, family;

k) Display of Patient Rights Law Posters in areas that are visible to any person entering facility.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The Office Health Facilities Licensing and Certifications conducts surveys of all certified long term care facilities. Surveys are scheduled subject to change up to three months in advance by supervisory personnel. Staff are informed of assignments at monthly staff meetings. All staff have been instructed that information regarding survey schedule is not to leave the office. All surveyor staff have signed, and understand the HCFA policy regarding "unannounced surveys". This policy is periodically reinforced at staff and office meetings.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

1. State orientation and HCFA sponsored basic surveyor training program is required of all long term care surveyors.
2. All long term care surveyor staff was required to attend Region III and HCFA sponsored "Documentation Training".
3. All results of surveys are reviewed by supervisory personnel prior to finalizing the report. Discrepancies are noted and discussed surveyors
4. Monthly staff meetings are held with time allocated for dissemination and review of Regional Office and HCFA directives and interpretations and overall problems noted in survey programs.
5. Special in-service sessions are planned and held for all survey staff when major changes in survey procedures, forms usage are mandated by HCFA.
6. Computer printouts of comparison of survey "citations" comparing Delaware and the other states in Region III and the nation are evaluated.

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STATE/TERRITORY: **DELAWARE**

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

1. See attached complaint process policy.
2. All plans of correction sent to facilities as a result of a complaint are reviewed for acceptability. Additional information or amended plans of correction are requested as indicated. Follow-up visits or phone contacts are scheduled dependent upon nature and extend of problems noted. Written periodic monitoring reports may be requested of the facility.
3. Prior to all annual surveys, team leader checks the complaint file to see if any investigations, for that facility, have occurred during the year. If deficiencies were noted, facility compliance is monitored.

HEALTH FACILITIES LICENSING AND CERTIFICATION
DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

COMPLAINT PROCESS POLICY

1. Written and telephone complaints (preferably when agency or individual is identified) will be investigated. If complaint(s) concern issues affecting health and safety of patients, investigation will be made within two work days. All other complaints will be investigated depending on the nature of the complaint as follows: a) within twenty work days or b) at the time of the next survey or c) the next follow-up visit.
2. Complaints will be investigated only when specific details and specific problems are identified.
3. Complaints involving an accredited hospital are to be referred in writing immediately to the Philadelphia Regional Office of Health Care Financing Administration. The Regional Office will direct the survey agency to evaluate specific areas of the hospital's operation. An onsite survey will be conducted in accordance with procedures set forth in the Medicare/Medicaid state Operations Manual section 3264 (Conducting An Accredited Hospital Complaint Investigation).
4. All complaint investigations involving federally certified facilities are to be performed and documented in accordance with the federal operations manual procedures.
5. A narrative report and deficiency forms as appropriate are to be completed by surveyor conducting complaint investigation.
6. All complaint investigations are unannounced and witnessed by another surveyor when possible. Observations of patient care must include at least a 3-5% sample size of total census which is randomly selected. Appropriate documentation will be made for these observations.
7. Name of complaintee and the findings of the investigation remain confidential. Letter is to be written by surveyor to complaintee of the facts of his or her investigation with proposed action if applicable.
8. Letter is to be written by surveyor and/or director to the health care facility indicating facts of the investigation and corrective action that needs to be made by the facility. State and Federal deficiency forms with plans of correction are to be utilized as appropriate.
9. All complaint reports are maintained on file with release of information only by the approval of the director or acting director or a court order. Notification of complaint findings will be made verbally and/or written to appropriate parties.

Effective July 1, 1978
Revised June 15, 1982; September 1, 1984; July 17, 1989; June, 1, 1990; January 1, 1991

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STATE/TERRITORY: **DELAWARE**

INSTRUCTIONS FOR COMPLAINT VISIT LOG

The following procedures are to record complaints received by the Office of Health Facilities Licensing and Certification:

Column A - Numerical number sequence of complaint being recorded.

Column B - Indicate date complaint was received at the office.

Column C - Identify the facility or agency the complainant has named.

Column D - Identify problems of service areas from the complaint worksheet .

Column E- Indicate the findings of the complaint investigation as to verified, not verified, not relevant.

Column F - Indicate if deficiencies have been sent to facility or agency and if for state and/or federal citations.

Column G - Indicate if complaint was referred to another agency for investigation by a yes or no. If yes, please indicate.

Column H - Who was informed verbally and in writing of the complaint findings; i.e. complainant, County Health Office, Delaware State Board of Health, Philadelphia Regional Office, etc.

YEAR_____

COMPLAINT VISIT LOG

A. Number of Complaint	B. Date of Complaint	C. Facility or Agency	D. Problem(s)	E. Verified Not Verified Not Relevant (V) (NV) NR)	F. Deficiencies State and/or Federal (S) (F)	G. Complaint Referred to Another Agency? Identify	H. Who Informed of Complaint Finding

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

FALSE CLAIMS ACT ATTACHMENT

1. The Delaware Health and Social Services (DHSS), the single state agency, will identify those entities, defined in §4.42(a)(1)(A), that must comply for CY 2007.
2. DHSS will request copies of an affected entity's written policies, and the plan to disseminate those policies to staff, within three (3) months of State Plan approval.
3. Affected entities' written policies and procedures, except employee handbooks, will be reviewed for compliance in accordance with §4.42(a)(3). These written policies and procedures must be submitted to DHSS by July 1, 2007.
4. Thereafter, DHSS will contact affected entities by January 31st for any update or change to its written policies. DHSS will accomplish this verification by entity survey.
5. New affected entities identified each year will be required to submit by April 1st their polices and dissemination plan, except employee handbooks, and will be handled per #2, 3, 4.
6. DHSS has a range of sanctions contained in its administrative regulation for non-compliance with Medicaid policies. These sanctions range from requiring a plan of correction to termination from the Medicaid program. These sanctions will be applied to non-compliance with the "Employee Education About False Claims Recovery."

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

METHODS OF ADMINISTRATION – CIVIL RIGHTS

Contracts and agreements with providers stipulate that they must abide by Title VI of the Civil Act of 1964. If a complaint is registered by a recipient, a hearing is scheduled in accordance with the state's hearing process at which the complainant and the provider present material relating to the alleged discrimination.

Complainants also have an option of presenting their complains directly to the Secretary of the Department of Health and Social Services, to the Human Relations Commission of the State of Delaware or to the Secretary of the Department of Health and Human Services.

Notices are posted in all agency officers as well as hospitals and institutions participating in the Title XIX Program. These notices briefly summarize the Civil Rights regulations. All employees throughout the State's Staff Development and Training Program are instructed in rules and regulations with regard to Civil Rights. All recipients are informed of their rights under the Civil Rights Act and advised to register complaints if it is alleged that any employee of the Division is in violation of the Act. Hearings are then scheduled to determine the validity of the allegation. The established hearing procedure is always available.

Periodic review of agencies and vendors is made in accordance with the established procedures.

The methods of administration for Title VI apply to the Division of Economic Services as they do to all Divisions within the Department of Health and Social Services.