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ABBREVIATIONS LIST

Abbreviation	Meaning
APM	Alternative Payment Methodology
ASC	Ambulatory Surgery Center
B&A	Burns & Associates, Inc.
CCDF	Child Care and Development Fund
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
DCCS	Division of Child Support Services
DDDS	Division of Developmental Disability Services
DHCQ	Division of Health Care Quality
DHSS	US Department of Health and Human Services
DHSS	Delaware Department of Health and Social Services
DMEPOS	Durable Medical Equipment, Prosthetics and Orthotics, and Supplies
DMES	Delaware Medicaid Enterprise System
DMMA	Division of Medicaid and Medical Assistance
DMS	Division of Management Services
DPH	Division of Public Health
DRG	Diagnosis Related Grouping
DSAAPD	Division of Services for Aging and Adults with Physical Disabilities
DSAMH	Division of Substance Abuse and Mental Health
DSS	Division of Social Services
DSHP	Diamond State Health Plan
DSSC	Division of State Service Centers
DVI	Division of Visually Impaired
E&M	Evaluation & Management
ED	Emergency Department
ESRD	End Stage Renal Disease
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
HCBS	Home- and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
I/DD	Intellectual and Developmental Disabilities
ICF/IDD	Intermediate Care Facilities for the Intellectually/ Developmentally Disabled
IMDs	Institutions for Mental Disease
LPN	Licensed Practical Nurse
MCO	Managed Care Organization
MEI	Medicare Economic Index
NEMT	Non-Emergency Medical Transportation
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
POC	Purchase of Care Program
PROMISE	Promoting Optimal Mental Health for Individuals through Supports and Empowerment
RBRVS	Resource Based Relative Value Scale
RHC	Rural Health Center
RUG	Resource Utilization Group
SFY	State Fiscal Year
SUD	Substance Use Disorder

Independent Study of Rate Methodologies for Services Delivered by the Divisions within the Delaware Department of Health and Social Services

EXECUTIVE SUMMARY

House Bill 225 of the 150th General Assembly requires DHSS to review the methodologies and rates paid to providers for services across all Divisions.

> ***Section 182***. *The Secretary of the Department of Health and Social Services shall work in partnership with the Director of the Office of Management and Budget and the Controller General on a comprehensive review of the multiple and differing methodologies used for provider rates for services delivered across the department for vulnerable and at-risk populations. Said review shall include a listing of provider rates by service, the populations served, associated federal matching funds and the most recent rate increase provided for such service. Further, the review shall include options for consideration, to the extent practical, to create a uniform and consistent methodology for addressing provider rates, to be considered annually through the budget process, in a manner that promotes access to service, addresses the workforce needs of the provider community, and establishes outcomes and metrics for the services delivered. The review and options shall be submitted to the Joint Finance Committee and the Governor by April 1 of this fiscal year.*

DHSS contracted with Burns & Associates, Inc. (B&A) to provide technical assistance in the development of this report. B&A is a consulting firm founded in 2006 whose primary client base is social services departments within state governments, including Medicaid, mental health and substance abuse, intellectual and developmental disabilities (I/DD), and services to children. Since its founding, B&A has worked with 33 state agencies in 26 states. A large component of B&A's work centers around the development of provider rates and associated tasks related to rate setting.

This report provides an assessment of the methodologies used to set rates. B&A does not make an assessment of the adequacy of any particular rate per se. The over-arching goal is to provide a framework for which the DHSS can assess on a regular basis the adequacy of the rates it uses by measuring against statewide or national benchmarks.

Background on Rate Setting

There is not a single rate schedule or rate methodology in place to pay for ***medical services***. In fact, the Centers for Medicare and Medicaid (CMS) have 17 different rate methodologies to cover the array of services covered in the Medicare program. Some methodologies, such as diagnostic related groupings for inpatient hospital services, were first introduced in 1983. Others, such as for home infusion therapy and opioid treatment, were just introduced in the last year. Section II of this report provides more information on the rate methodologies used by Medicare.

Unlike many of the medical service categories, there are no standard methodologies set by CMS for ***home- and community-based services*** (HCBS) in Medicaid waivers, primarily because these are not services offered in the Medicare program. As a result, State Medicaid Agencies have taken many approaches to developing the rates paid for HCBS. Compared to medical services, the approaches to rate setting for HCBS, though not brand new, are not as pervasive in the field as many of the methodologies for medical services.

Recommendations

Based on our review of claims and managed care encounter data from the State's data warehouse, the in-person interviews with staff involved in rate setting within each DHSS Division, and our experience setting and reviewing rates for a variety of medical and social services for other state agencies, B&A

offers recommendations to improve the rate setting process across DHSS. These recommendations relate to medical services administered by the Division of Medicaid and Medical Assistance (DMMA), to HCBS services administered by multiple DHSS Divisions, and to contracts administered by most DHSS Divisions. Specifically, we offer recommendations on how to easily pinpoint wide variations from either industry standards or third-party benchmark data such as the prevailing wage for job categories that are employed by various provider agencies. Therefore, our recommendations are centered around ways to adapt Delaware's DHSS to common industry standards as well as ways to strengthen rate methodologies that are specific to Medicaid-covered services.

The specifics around each of the nine recommendations shown below appear in Section VIII of this report. The recommendations are provided in summary format below.

1. ***DHSS is encouraged to build rate methodologies that are specific to each service that is purchased and not to build a uniform "one size fits all" methodology. That being said, some service categories can have rate methodologies that are common in the way that they are built. The difference lies in accounting for variations based on the definition of the service being purchased***.

   B&A's experience has found that there is never a single "rate schedule" covering all services that are paid by health purchasers. This is true in the commercial market as well as the public sector markets (Medicare, Medicaid, Department of Defense and Veteran's Affairs). As an example, Exhibit 1 on page II-4 itemizes the 17 different rate schedules developed for the Medicare program.

   Although B&A has offered a prioritization to focus resources on areas of opportunity within the DMMA service array, B&A does not believe that this needs to be the highest priority. Specific recommendations for DMMA services appear later in this list of recommendations.

   Instead, B&A suggests that priority be centered on rate schedules for which there is no CMS benchmark. B&A offers a specific recommendation below on how to build consistency in the rate methodology for these services while also adapting to the specifics of each service definition.

2. ***DHSS is encouraged to develop a long-term roadmap for assigning the periodicity of updates of rates for all of its services.***

   More specifically, any guiding roadmap should also include the following:
   - Track if Medicare has a comparable methodology in place that could be considered;
   - Track whether DHSS will incorporate a value-based component to its rate methodology;
   - Identify the resources (both internal and external) to make changes to the methodologies;
   - Assess where there are gaps in current resources to complete this work;
   - Identify the modes of communication to external stakeholders required when changes occur;
   - Prepare, in advance, the timing and cadence of updates to align with annual budgeting;
   - Prepare, in advance, the timing needed to introduce value-based initiatives into each rate methodology where it is warranted and any associated quality-based reporting needed to ensure that the value-based initiative has a positive return on investment.

   B&A believes that the development of a roadmap such as the one described above could be prepared within six months to cover all significant service categories delivered by DHSS Divisions.

3. ***B&A recommends that DHSS consider augmenting the existing staff currently used to develop and maintain rate methodologies and to clearly define roles and responsibilities for the staff that perform this function***. Specific staffing suggestions, by Division, appear in Section VIII.

4. ***B&A recommends to all DHSS Divisions that a more formalized Public Notice process be initiated to inform providers and other stakeholders when rate changes are being contemplated***. CMS uses the process of issuing Proposed Rules, then allows for a period of public comment, then issues a Final Rule when rate changes are made.

5. Although a Public Notice is helpful, B&A has found that ongoing communication with providers on upcoming rate changes is also essential. Therefore, ***B&A recommends that when rate methodology changes are undertaken, DHSS should build a project-specific work plan that incorporates periodic meetings with the providers affected by the rate change throughout the project***.

6. B&A found that the accuracy and completeness of the manuals that describe the rate methodologies and billing guidance to providers across DHSS were mixed or non-existent. ***B&A recommends that, for each major category of service, there should be a dedicated section in the Provider Manual that describes the rate methodology in detail and that this section is updated timely when any rate changes occur***.

7. ***With respect to opportunities to modernize the rate methodology for HCBS (non-medical services), B&A recommends that DHSS develop a process to capture provider actual costs as well as independent market-based costs to use as a comparison when setting HCBS rates. Rates for these services can be built on a model that is built "from the ground up" and specific to the Division's needs***.

   <u>The services covered in this recommendation pertain most specifically to Division of Developmental Disability Services, the Division of Substance Abuse and Mental Health, the Division of Services for Aging and Adults with Physical Disabilities, and the Division of Social Services for child care support</u>.

   There is not a uniform method in which provider costs are captured to deliver HCBS services like there is, for example, with hospitals and nursing facilities. Even when costs can be captured, there is often a "chicken-and-egg" scenario. If the rate of payment is below-market for a service, then the costs that providers will report will be below-market because that is what the provider can afford to spend to remain financially viable.

   B&A proposes that, although the rates themselves will differ, the process upon which how rates are developed can be fairly standardized if the following principles are applied for each service:

   a) Carefully review the definition of the service and the unit of measurement (e.g., per hour, per day) to ensure the Division is cognizant of what it wants to pay for.
   b) Track and maintain if there are specific federal or state rules or policies that must be factored into the cost of delivering the service.
   c) Collect cost information from providers to inform the development of a new rate.
   d) Collect market-based data *outside of provider costs* to benchmark against the costs reported by providers. For example, a provider's wage costs may be lower than the going market rate because the current rate only supports hourly wages below market.
   e) Build and continually updated (such as annually) a "benchmark rate"—that is, what is the rate that could be supported if funds were available. The benchmark rate factors in actual provider costs and market-based conditions (e.g., the continual increase in personnel health insurance costs).
   f) When state resources are limited, if the benchmark rate is not affordable, work towards parity to get all services up to a threshold level.

Within a service category, B&A recommends that the methodology and approach be consistent to set the rates, but that there may be variations required to account for the following:

- A client's level of need (e.g., support in the home will vary for someone with underlying medical complexities than for someone without these medical conditions);
- The group size (e.g., a 1:1 service is much more expensive than staffing a 1 employee:4 client group);
- The service setting (e.g., in-home or facility-based);
- Staff qualifications or training (e.g., RN vs LPN, licensed psychologist vs peer support);
- Geography (e.g., urban vs rural); and
- Provider supply (e.g., if providers are limited in a specific area of the state to meet the need)

B&A recommends that the following costs always be captured for consideration in the development of rates for HCBS:

- Direct worker wages
- Direct worker benefits
- Direct worker productivity (e.g., how much of an 8-hour day is client facing versus travel time, record keeping, attending training, etc.)
- Program support (e.g., the non-labor costs specific to deliver the service)
- Administration (e.g., back office costs)

It should be noted that DDDS has adopted this approach for recent updates it has made for services delivered by providers to persons with intellectual and developmental disabilities. Benchmark rates has been developed for each service, but the funding was not available to always set the rate at the benchmark level.

The DMMA has received a federal grant to examine the rates paid for delivering services to individuals with substance use disorder. The process described above will be used to assess the rates to pay to providers who deliver these services. The project is just starting in June 2020 with the goal for recommendations to rate changes to be completed by March 2021.

8. Using the theme as described in the prior recommendation, other Divisions can also use this method when entering contract negotiations even if the actual rate is not published. ***B&A recommends that Divisions that use the contracting method to pay providers to develop a rate corridor that they are willing to accept from providers in the bid process that is driven by market data***.

   In other words, Divisions that do not publish fee schedules per se can still use the benchmarking method to determine the range of acceptable rates offered by a bidder that they would accept under a specific service contract. Prior to accepting a provider's proposed rate, the Divisions could conduct research to "build up" the cost components of a rate to determine this acceptable range. Further, any opportunities where a value-based component such as performance targets should be explored that may influence the final rate negotiated with the provider. The Division may or may not choose to publish what this acceptable rate range would be.

   This approach is most likely appropriate for the Division of Public Health, the Division of State Service Centers, the Division for Visually Impaired, and the Division of Social Services for services other than child care support.

9. With respect to services covered by the Division of Medicaid and Medical Assistance (DMMA), the DMMA has adopted protocols to keep current with Medicare rates and rate methodologies on most of

the services that it sets rates for. When this protocol is used, it is often the case that the Medicaid rate is on par or just slightly less than the Medicare rate. An example of this is the annual update for most physician and other professional services.

Whereas the DMMA has built more refinement and processes into the services that it is responsible for than some of the other Divisions, B&A does offer some specific recommendations related to the methodology for some acute health care services:

- ***For inpatient hospital services, DHSS should consider changing its reimbursement methodology from a per discharge rate that is not based on patient acuity to a per discharge rate based on patient acuity using a diagnosis related grouping (DRG) system.*** This would align the DMMA with the way that 37 other State Medicaid Agencies and Medicare pay for hospital services.

- ***For outpatient hospital services, DHSS should consider changing its reimbursement to a more sophisticated rate structure that incentives value and efficiency such as the Medicare Outpatient Prospective Payment System or 3M's Enhanced Ambulatory Patient Grouping***. For services where hospitals bill the DMMA different amounts and the payment, therefore, is hospital-specific, there is an opportunity for the DMMA to modernize this portion of the payment methodology by using the Medicare or 3M systems that follow the principal of paying for a combined group of related services in an outpatient visit together in one rate versus piecemeal.

- ***Although the actual per diem rates paid may differ from Medicare's, DHSS should consider immediately migrating to CMS's new methodology to pay for nursing facilities since the current methodology that has been in place for over 20 years will not be supported by CMS beginning in October 2020***. Beginning in October 2019, CMS changed its methodology to what is called the Patient-Driven Payment Model (PDPM). The PDPM is based on a new classification system that better reflects the supports needed for today's nursing facility residents which is different from the previous grouping method established more than 20 years ago. CMS is phasing out support of its old system on September 30, 2020. This requires Medicaid agencies to follow Medicare's new PDPM method or develop an alternative to the current method.

Process Used to Inform the Recommendations

B&A used both a qualitative and quantitative approach to collecting and analyzing the rates paid for services across DHSS. In October 2019, B&A staff members convened in-person interviews with representatives from each DHSS Division to learn more about the services for which they were responsible, the clients that they serve, and the providers that they contract with. The B&A team queried each Division about the source data, if any, used to inform how individual rates are set; the process for setting rates and whether it is uniform across service categories; the current state of the provider base to deliver services and whether any challenges exist to attract and/or retain providers; and any suggestions on how the rate setting process could be improved at their Division.

In addition to collecting this feedback, the B&A team requested and received individual claim-level detail for services that are billed by providers to the Delaware Medicaid Enterprise System (DMES). B&A coordinated with a state Core Team comprised of staff from DHSS and the Office of Management and Budget (OMB) on the analytics to complete on this data and the method of presentation for this report. Additionally, measures were developed to inform a hierarchy of the recommendations that B&A would make related to opportunities for developing state-of-the-art rate methodologies across DHSS services.

Because of the vast array of services delivered by DHSS, the services were categorized into three major groupings:

- Services covered in the Medicaid program administered by the DMMA or its contracted managed care organizations. For the review of these services, the primary data source was claims from the DMES.

- Services that are delivered in the home or community that are not medical in nature, including services offered in Medicaid waivers and administered by the DMMA or other Divisions in DHSS. Claims from the DMES were also used in this review, although there are some instances where not all data is available in the DMES.

- Services administered by other DHSS Divisions for which providers are paid by contract and not by individual claim. For the review of these services, B&A requested information from each Division through a survey instrument.

How Results are Organized in this Report

For each of the categories mentioned above, a 1-page dashboard report was created to display key information about each service category. In Section V, there are 20 dashboard reports to show information on the DMMA services. In Section VI, there are five dashboard reports to show information on the HCBS services. In Section VII, there are five dashboard reports to show information about contracts from other Divisions' services.

Within the DMMA scope of services, rankings were assigned to each of the 20 categories that assess the relative viability for rate reform. Six domains were used to make this assessment, including:

- Percent of dollars spent on this service of the total Medicaid budget (including waiver services);
- Percent of service dollars spent on this service in Medicaid managed care;
- Rates of usage of the service among Medicaid enrollees;
- Measurement of the provider base using a ratio of providers-to-Medicaid enrollees;
- Level of opportunity for DHSS to modernize its rate methodology (i.e. is there a Medicare standard); and
- Level of opportunity to add a value-based component to the rate setting methodology.

The final scoring for each service category across these domains appears in a Summary Scorecard on page IV-3 of the report.

On each dashboard report, information is also presented that states the last time the rate(s) for the service were updated, the top five procedures or revenue codes and their associated rates, and information about whether there is a Medicare equivalent rate. Where possible, DHSS's rate as a percentage of Medicare's rate is shown.

Information on HCBS rates is displayed in a similar manner in Section VI, although some items shown in Section V do not appear on Section VI reports because they are not relevant (e.g., comparisons to Medicare where none exist). Information on other DHSS Division contracts are shown in Section VII, including the total dollars contracted, the method of contracting (e.g. competitively bid or not), and the top contracts (based on dollars) for services delivered to Delawareans.

In the appendix, a listing all of all current rates available, by service category, are provided.

Independent Study of Rate Methodologies for Services Delivered by the Divisions within the Delaware Department of Health and Social Services

SECTION I: OVERVIEW OF DELAWARE'S DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Introduction

The Delaware Department of Health and Social Services (DHSS) consists of 11 divisions. Each Division carries responsibilities specific to the services that it delivers to Delawareans. The overview/mission of each Division is shown below.[1]

Child Support Services	To collect, distribute, disburse and account for child support collections from non-custodial parents to families in Delaware and across the country.
Developmental Disability Services	Valuing persons with intellectual and developmental disabilities, honoring abilities, respecting choice, achieving possibilities, and working together to support healthy, safe and fulfilling lives.
Health Care Quality	To protect those receiving services in acute, outpatient and long term care health settings through the promotion of quality care, quality of life, saafety and security for patients.
Medicaid and Medical Assistance	To improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner.
Public Health	To protect and promote the health of all people in Delaware.
Services for Aging and Adults with Physical Disabilities	To promote dignity, respect and inclusion for older adults and people with disabilities.
Social Services	To provide prompt, respectful and accurate services that promote the potential for self-sufficiency for all Delawareans.
State Service Centers	To provide convenient access to human services, assist vulnerable populations, support communities and promote volunteer and service opportunities.
Substance Abuse and Mental Health	To improve the quality of life for adults with behavioral health conditions by promoting their health and well-being, fostering their self-sufficiency and protecting those who are at risk.
Visually Impaired	To provide educational, vocational and technical support to empower and foster independence for Delawareans with visual impairments.
Management Services	Reponsible for managing all of the functions that are centralized across the Department of Health and Social Services.

[1] Retrieved from Division Director testimonies to the Joint Finance Committee February 25-27, 2020.

Independent Study of Rate Methodologies for Services Delivered by the Divisions within the Delaware Department of Health and Social Services

Legislative Request

House Bill 225 of the 150th General Assembly requires DHSS to review the methodologies and rates paid to providers for services across all Divisions.

> ***Section 182***. *The Secretary of the Department of Health and Human Services shall work in partnership with the Director of the Office of Management and Budget and the Controller General on a comprehensive review of the multiple and differing methodologies used for provider rates for services delivered across the department for vulnerable and at-risk populations. Said review shall include a listing of provider rates by service, the populations served, associated federal matching funds and the most recent rate increase provided for such service. Further, the review shall include options for consideration, to the extent practical, to create a uniform and consistent methodology for addressing provider rates, to be considered annually through the budget process, in a manner that promotes access to service, addresses the workforce needs of the provider community, and establishes outcomes and metrics for the services delivered. The review and options shall be submitted to the Joint Finance Committee and the Governor by April 1 of this fiscal year.*

DHSS contracted with Burns & Associates, Inc. (B&A) to provide technical assistance in the development of this report. B&A is a boutique consulting firm founded in 2006 with a home office based on Phoenix, Arizona. B&A's primary client base is social services departments within state governments, including Medicaid, mental health and substance abuse, intellectual and developmental disabilities (I/DD), and services to children. Since its founding, B&A has worked with 33 state agencies in 26 states. A large component of B&A's work centers around the development of provider rates and associated tasks related to rate setting such as creating service definitions, billing requirements and fiscal modeling of rate changes. Another key focus area is the evaluation of public programs including the review of operations, access to services and financing.

Through its work in other states, B&A has experience either setting or examining the rates paid for many of the services that are the responsibility of DHSS divisions including the following:

Acute Care	Other Services
Inpatient hospital	Nursing facility
Outpatient hospital	Institutions for Mental Disease (IMDs)
Disproportionate share payments	Intermediate Care Facilities for the Intellectually/Developmentally Disabled (ICF/IDD)
Ambulatory surgical centers	
Physician and other specialists	Community-based services for the I/DD population (e.g. group home, foster care, day programs, in-home, supported employment)
Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	
Home health agencies	Community-based services for treatment of mental health and substance abuse
Physician-administered drugs	
Anesthesia	Early intervention programs
Laboratory and radiology	Child care services
Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS)	
Ambulance	
Non-emergency transportation	

Until this engagement, B&A has completed no work in Delaware for the State or for any provider or any managed care organization under contract with the State.

Organization of this Report

This report was developed by B&A in collaboration with a Core Team comprised of individuals from DHSS, the Office of Management and Budget (OMB) and the Controller General's Office. In response to the requirements enumerated in the legislation, B&A has organized the report in the following manner:

Section II provides a brief background on common methodologies used by Medicare and state Medicaid agencies to pay for services. There is also a discussion of where value-based components have been weaved into existing payment methodologies.

Section III provides the reader with the approach used by B&A to conduct this study. One-page dashboards were developed for major service categories that offer key indicators on the total expenditures, total users and total provider base for each service category. The data used to inform B&A's assessment of opportunities for rate methodology reform are also shown on these dashboard reports. This section provides an orientation to the dashboards that are shown later in the report.

Section IV describes B&A's methodology for assessing the opportunity for rate methodology reform. Using a series of measures where the options for opportunity are ranked, a dashboard is shown to easily identify the areas of greatest opportunity across DHSS services based on the ranked score.

Section V provides the detailed findings related to the service categories that are the responsibility of the Division of Medicaid and Medical Assistance (DMMA). A total of 20 dashboards were created for different service categories. A one-page introduction appears before each dashboard report. As required by the legislation, a listing of the top provider rates by service are shown. Information about the populations served, associated federal matching funds and the most recent rate increase provided for such service are shown on each dashboard.

Section VI follows a similar pattern to Section V, but in this section, the dashboard reports are for service categories that represent home- and community-based services delivered through the DMMA or through Medicaid waivers. The services in the Medicaid waivers are the responsibility of the Division of Developmental Disabilities Services, the Division of Aging and Adults with Physical Disabilities, and the Division of Substance Abuse and Mental Health. Another component of this section is a comparison of the rates for services that are paid by multiple divisions within DHSS.

Section VII provides dashboards that summarize the methods for payment of services in the DHSS Divisions not referenced in Sections V and VI. For other DHSS Divisions, specific fee schedules have not been established. Almost all of the services are paid for through provider-specific contracts. Information on the types of contracts that have been developed are summarized in a dashboard report specific to each DHSS Division.

Section VIII summarizes B&A's recommendations related to options for the State to consider to align rate schedules with industry standards. Additionally, recommendations are made for ways to consider rate development and rate updates for services where there is currently no industry standard, particularly for services delivered in Medicaid waivers and in non-Medicaid social service divisions. The recommendations tie to ways to factor in, as the legislation requests, consistency across rate methodologies, access to service, workforce needs of the provider community, and the integration of value-based or outcome-based components in the rate methodology.

The **Appendix** to this report lists individual fee schedules by category of service.

SECTION II: BACKGROUND ON COMMON RATE SETTING METHODOLOGIES

Introduction

When it comes to paying for medical and social services, there is not one pre-defined method for how these services are paid. In fact, it is industry standard to have multiple varying methodologies. This is because the method in which services are delivered varies—e.g., per service, per visit, per day, per hospital stay, or per episode period (such as home health visits). Although their methodologies must be approved in advance, State Medicaid Agencies have wide discretion from the Centers for Medicare and Medicaid Services (CMS) on the ways in which they pay for services. Over the years, for some services there are a few common approaches that have surfaced for specific categories of service (e.g., hospital, nursing facility and physicians). For other categories, there remains wide variation on the methodologies used for medical care services (e.g., home health, medical equipment and supplies and behavioral health services).

CMS has created a number of rate setting methodologies to pay for the variety of services that are covered in the Medicare program. Many State Medicaid Agencies have either adopted these methodologies in their Medicaid programs wholesale or have utilized key concepts from the CMS methodologies and adopted a state-specific solution for their Medicaid program.

For other services delivered at the state level, however, there is no national guidance from CMS. This is particularly true for services delivered in the home or community-based setting through Medicaid waivers. Because these types of services are not covered by Medicare, there has been no national approach to rate setting design. Further, the types of providers delivering these services are—compared to acute care medical services—often much smaller in size and less sophisticated in tracking costs at the level that is often needed to set a rate to pay for individual services. As a result, State Medicaid Agencies have historically taken very different approaches to establishing the rates paid for home- and community-based services (HCBS) for services delivered to the elderly and persons with physical disabilities, persons with intellectual and developmental disabilities (I/DD), and persons with behavioral health conditions and substance use disorders.

That being said, many State Medicaid Agencies in the last decade have re-examined the methodologies used to set the rates paid for these services. Although the criteria used may vary by states, more emphasis has been placed in the rate development process on the workforce required (i.e., the hourly wage and benefits paid to a direct service professional) and the other program-related expenses specific to the service being rendered. Further, CMS has been conducting more scrutiny on the rate methodologies developed by states when they renew their Medicaid waivers (which is required every two to five years depending upon the type of waiver pursued).

In our work assisting 13 different states on this particular topic, Burns & Associates (B&A) has also observed an unintended consequence of states pursuing different Medicaid waiver authorities with rate schedules specific to each waiver. It is often true that the responsibility for administering each Medicaid waiver lies in different divisions within state government. As a result, rate schedules for different waivers are built in isolation. Often times, however, the provider pool that delivers the services across waivers may be the same. Therefore, state divisions are competing with each other for the same labor pool across waivers depending upon the rate they pay for the same or similar services. On this matter, Delaware is no exception. B&A's review of the potential prevalence of this interaction across waivers is further discussed in Section VI of the report.

To further complicate matters, State Medicaid Agencies that contract with managed care organizations (MCOs) typically allow the MCOs to negotiate their own rates with providers for the medical services which the MCO is responsible for delivering. Although many states require that the rate set by the state

in its fee-for-service program (the portion of the program not managed care) is the established rate "floor" that a provider may receive, that is not always the case. B&A has observed in other states that if a State Medicaid Agency has not updated its fee-for-service rate schedule for many years and the technology or efficiencies have improved such that some rates on the fee schedule have actually gone *down* in the industry, the MCOs—when they have the authority to pay less than the state's fee-for-service rate—will often do so. This is particularly true in the area of radiology, medical equipment and supplies.

It has also been B&A's experience that MCOs contracted in many Medicaid programs often look to the state's fee-for-service fee schedule as a benchmark, of sorts, even if the MCO does not adopt this fee schedule as is. For example, an MCO may pay using the same *methodology* that the state's fee-for-service program was based on even if the MCO does not pay the same *rate* as in fee-for-service. Stated simply, in states where managed care is the prevalent delivery model, the fee-for-service fee schedule is often not the true measure of what providers are being paid. This is the case in Delaware since more than 85 percent of total spending in Delaware' Medicaid program is in the managed care model. As a result, the fee-for-service rates that are published may, in some cases, actually be utilized infrequently because the MCOs have set their own payment arrangements with providers.

Although MCOs often have the flexibility to create their own rate methodologies, B&A has found that many MCOs do not exercise this option. MCOs prefer to rely on the Medicaid fee-for-service rate schedule or choose to negotiate, for example, a rate to providers equivalent to 105% of the fee-for-service schedule. Without regular updates to the fee-for-service fee schedule, a higher degree of variability will occur over time and providers will use this to their advantage. For example, if a Medicaid fee schedule has not been updated in a number of years for a particular service, then what may have been a negotiated rate by the MCO to providers of 105% of the fee-for-service rate when the fee schedule was first updated becomes 125% of fee-for-service rate as the number of years go on that the fee-for-service rate schedule has not been updated. Yet another provider in the same pool will try to negotiate, for example, 150% of the fee-for-service rate. So, in addition to there being variability between the rate paid under fee-for-service compared to managed care, absent regular updates to the fee-for-service fee schedules, there may also be greater variability in the rate to different providers for the same service.

In most cases, states are not required to track and publicly report the rates that they pay for the services that they purchase other than at the single time that the rate is actually changed in a public notice process. This, most likely, is due to the fact that there are few instances where rate updates are required by federal law. The US Department of Health and Human Services (DHHS), through its CMS agency, does not require that periodic rate surveys must be conducted for Medicaid-covered services. But the DHHS's Administration of Children & Families, Office of Child Care does require a survey. Once every three years, states conduct a market rate survey that reflects the variations in the rate charged for child care services by geographic area, type of provider, and age of the child.[2] This is a requirement as part of the Child Care and Development Fund (CCDF) which is used to fund subsidies to eligible low-income families to ensure equal access to the full range of child care available in their community.

Any rate updates are at the discretion of the states. There are some notable exceptions to this. For federally qualified health centers (FQHCs), State Medicaid Agencies must ensure that FQHCs are paid at a rate that either accounts for an annual inflation amount or an alternative rate that has been approved by CMS. This provision is memorialized in federal law. For some other Medicaid-covered services, CMS requires that State Medicaid Agencies not pay greater than what Medicare would have paid (in aggregate dollars, even if specific service rates can be higher). Specific tests are required for inpatient and outpatient hospital services, nursing facilities, and some selected durable medical equipment and supplies.

[2] https://www.acf.hhs.gov/occ/faq/what-are-the-new-requirements-regarding-the-market-rate-survey-used-to-set-payment-rates

Rate Methodologies Used for Medical Services in the Medicare Program and Many State Medicaid Programs

The CMS website[3] outlines 17 different rate methodologies for services covered by the Medicare program. Some methodologies have been in place for decades while others are brand new. For example, Medicare has been paying for inpatient hospital services on a per inpatient stay basis using diagnosis related groupings (DRGs) for 37 years. Although this rate schedule and the mapping of DRGs may change from year-to-year, this methodological approach has been consistent throughout the years. The methodology used to pay for outpatient hospital services was first introduced 20 years ago. The methodology used to pay physicians and other practitioners has been in place for 28 years. Alternatively, the rate methodology to pay for home infusion therapy will be officially implemented by Medicare on January 1, 2021 (temporary rates have been in place for CY 2020). The rates established for opioid treatment were introduced January 1, 2020.

Exhibit 1 that appears on the next page lists each of these rate methodologies. Each of these categories will have its own rate schedule. Some rate schedules list rates at the individual service level while others list rates at the individual provider level. Other rate schedules list a single rate paid to all providers.

The exhibit segments the rate schedules by the type of rate schedule.

- A **Per Service Rate** schedule means that that each service will be paid a specific rate. For example, a hospital may submit an outpatient claim for an individual that presented to the emergency department (ED) with a broken arm. The claim will have individual lines billed for the ED visit, the x-ray of the arm, the cast for the arm, and perhaps some drug given to the patient. Each of these lines will have a different rate that is paid to the provider. For some lines on the claim, some ancillary services may roll into the rate paid for the primary service.

- A **Per Diem Rate** schedule means that the provider is paid for all services rendered to the patient on a single day. This type of fee schedule is often used when the type of services delivered on a day-to-day basis are fairly predictable, such as in the case of nursing facility care.

- A **Per Case Rate** schedule means that the provider is paid one rate for all services rendered during a single period of care. This methodology is often used in a hospital setting. For example, the rate paid to the provider covers the entire length of stay while the individual is an inpatient at the facility.

- A **Per Episode Rate** schedule is the newest method used by CMS. The rate developed is intended to cover a period of time that the provider is serving the patient. By paying for an entire episode, the rate recognizes that some periods in the episode will require more time commitment from the provider than other times. The rate is intended to smooth out this variation. For example, Medicare's home health episode rate is based on a 60-day period of time.

[3] https://www.cms.gov/Medicare/Medicare Refer to the subheading Medicare Fee-for-Service Payment.

Exhibit 1
Types of Rate Schedules Developed by CMS for the Medicare Program

		Acuity Adjustment?	Value Based Component?	Quality Reporting?
Per Service Rate	Ambulance	No	No	No
	Ambulatory Surgical Center	No	in progress	No
	Clinical Laboratory	No	No	No
	Durable Medical Equipment, Prosthetics & Orthotics	No	Yes	No
	Clinics	No	No	No
	Hospital Outpatient Services	No	No	No
	Physicians and Nurse Practitioners	No	Yes	Yes
Per Diem Rate	Home Infusion Therapy	Yes	No	No
	Hospice Care	No	No	Yes
	Hospital Inpatient Psychiatric Care	Yes	No	No
	Skilled Nursing Facility	Yes	No	Yes
Per Case Rate	Hospital Inpatient Acute Care	Yes	Yes	Yes
	Hospital Inpatient Rehabilitation Care	Yes	No	Yes
	Hospital Long Term Care	Yes	No	Yes
Per Episode Rate	End Stage Renal Disease Dialysis	Yes	No	Yes
	Home Health (nursing/therapies)	Yes	No	Yes
	Opioid Treatment	No	No	No

The attributes within a methodological structure of the rate schedule can also vary. As seen in the last three columns of the exhibit, CMS has sometimes built in an ***acuity adjustment*** to the rates set. For example, for inpatient hospital acute care there are 759 different DRG categories. The rate paid to the hospital varies based on the diagnoses presented by the patient. There are obvious distinctions, for example between cardiology-related conditions and respiratory-related conditions. But there is also segmentation in the rates paid within major condition categories. For example, there is one payment for a patient classified under a DRG for leukemia and a different payment for a patient with leukemia who is also receiving chemotherapy treatment. In the case of skilled nursing facilities, residents are assessed across a number of dimensions such as the assistance they need with activities of daily living. The per diem rate paid to the nursing facility will vary based upon the needs of the resident.

CMS continues to introduce ***value-based components*** into many of its reimbursement methodologies, but they do not yet exist in all methodologies. As an example, for durable medical equipment, prosthetics and orthotics (DMEPOS), there is a national fee-for-service rate schedule with some locality adjustments for individual items in this category. However, CMS introduced a competitive bid concept that is at the major metropolitan area across the country. Vendors bid to compete against (i.e. offer below) the established fee-for-service rate. Now, the DMEPOS rate schedule shows the national fee-for-service rate as well as the rate determined through the competitively-bid process in that region of the country.

Using the inpatient hospital rate schedule again as an example, CMS computes the rate of hospital readmissions among Medicare beneficiaries for each acute care hospital in the country on an annual basis. Depending upon how an individual hospital's readmission rate compares to its peers, the hospital's rate

for a 12-month period may be reduced by one to three percent from what it could have been if the hospital has a higher-than-expected readmission rate.

The concept of ***quality reporting*** is also relatively new in the Medicare program. In most cases, CMS is using this reporting to capture baseline data that may later inform changes to rate development. For now, it is typically for reporting purposes only. However, this information provides another view into the value of the reimbursement paid to providers for the services rendered. Examples of quality-based reporting include online queries where users can display comparisons of nursing facility providers[4], acute care hospitals[5], rehabilitation hospitals[6], long term care hospitals[7], physicians[8], home health agencies[9], dialysis centers[10] and hospice providers[11].

State Medicaid Agencies are not obligated to use the Medicare methodologies to pay for the equivalent services in its Medicaid program. But many states have adopted at some of the conceptual frameworks used CMS in the Medicare program. For example, the vast majority of State Medicaid programs pay for inpatient hospital services using some type of DRG case payment system. Most states also use an acuity-based per diem methodology to pay skilled nursing facilities. Although the methods to assign acuity levels may differ, the fundamentals of the rate methodology are similar to Medicare' approach.

Rate Methodologies Used for Medicaid Waiver Services

Unlike many of the medical service categories mentioned in the previous section, there are no standard methodologies set by CMS for home- and community-based services (HCBS) in Medicaid waivers, primarily because these are not services offered in the Medicare program. As a result, State Medicaid Agencies have taken many approaches to developing the rates paid for individual HCBS.

B&A staff have assisted many states in developing rate models that we first introduced almost 20 years ago that are now often used as a method to develop state-specific solutions. These models used cost information from HCBS providers as well as external market-based information. B&A has found that many small HCBS providers are solely funded or almost completely funded by State Medicaid Agencies. As a result, provider costs are directly related to the rates paid by the Medicaid program. If the rate is low, this will then dictate, for example, the hourly wage paid to direct service professionals. To balance against this direct relationship, B&A and others also survey independent market factors such as the average wage paid in the state for a labor category as reported in the Bureau of Labor Statistics. This information is compared to actual wages paid by providers to assess where gaps may be found in the current rate paid by the Medicaid agency.

Other factors inform the development of individual service rates using this market-based model approach. Key factors that B&A also considers in its rate development with states include:

- Fringe benefits paid to staff (e.g., health insurance, vacation and sick pay, retirement benefits);
- Assumptions for non-billable time (e.g., time that the provider cannot bill the State when not face-to-face with a client such as travel time to the client's home, training time, client file notes, etc.);

[4] https://www.medicare.gov/nursinghomecompare/search.html
[5] https://www.medicare.gov/hospitalcompare/search.html
[6] https://www.medicare.gov/inpatientrehabilitationfacilitycompare/
[7] https://www.medicare.gov/longtermcarehospitalcompare/
[8] https://www.medicare.gov/physiciancompare/
[9] https://www.medicare.gov/homehealthcompare/search.html
[10] https://www.medicare.gov/dialysisfacilitycompare/#search
[11] https://www.medicare.gov/hospicecompare/

- Capital costs (e.g., buildings for day programs, home costs for residential programs, vehicle costs for transportation);
- Program-related expenses (e.g., costs to run adult day health activities or an I/DD day program);
- Other transportation costs in addition to vehicles (e.g., miles driven per week); and
- Administrative costs (e.g., costs to run the business not directly related to client-facing activities).

The construct of these market-based models even though the specific elements like the ones stated above may vary based on each service.

In addition to developing a standard rate for a service, other factors may need to be considered to modify the standard rate. These "modifiers" on the rate may include, but are not limited to:

- The licensure level of the professional delivering the service (e.g., an RN, LPN or Nurse Aide for in-home health or a Ph.D. or Master's level psychologist for a behavioral health service);
- The acuity level of the individual(s) served (e.g., persons with I/DD at different functioning levels or persons with I/DD with or without medical needs as well);
- The geographic location of the individuals being served (e.g., urban versus rural differentials); and
- The staffing requirements needed to serve clients (e.g., a 1 staff-to-1 client ratio versus a 1:3 ratio).

Whereas many medical services are defined using nationally-recognized service codes and service definitions, state waiver programs may often use the same service code but the definition of the service itself can vary across states. As a result, it is not always feasible to do a state-by-state comparison of rates even on the same service code without knowing more about how each state defines the service in its program(s).

Value-based components are starting to appear in some HCBS rates, but this a fairly new concept nationally. Many states are still working on the process to provide clarity and standardization in the assumptions around the rates that they do set before introducing a value-based component. Nonetheless, there is some evidence of value-based initiatives being developed. For example, B&A is assisting one state's I/DD waiver program in creating a value-based (i.e., incentive) payment for individuals with I/DD seeking meaningful employment. The provider's incentive payment is defined by the length of time an individual not only obtain, but also, retain employment either with or without additional supports.

Rate Methodologies Used for Non-Medicaid Services

In B&A's experience, we have not seen national standards or benchmarks to pay for health and human services that are delivered outside of Medicaid. This may be because there is not a federal partner such as CMS that needs to approve the rates themselves. Delaware's DHSS is not different from other states in this regard whereby the typical method to set rates is either a subjective decision made by state policymakers as to the rate to pay for a service or a request for competitive bids from providers to determine a rate that the market will offer to the state. Some examples of services in this category include:

- Case management for grant programs
- Public health programs such as immunizations and screenings that are intended to serve the entire population
- Emergency housing

SECTION III: APPROACH TO CONDUCT THIS STUDY

Introduction

Burns & Associates (B&A) used both a qualitative and quantitative approach to collecting and analyzing the rates paid for services across the Department of Health and Social Services (DHSS). In October 2019, B&A staff members convened in-person interviews with representatives from each DHSS Division to learn more about the services for which they were responsible, the clients that they serve, and the providers that they contract with. In addition to confirming this information, the B&A team also asked each Division about:

- The source data, if any, used to inform how individual rates are set;
- The process for setting rates and whether it is uniform across service categories;
- The current state of the provider base to deliver services and whether any challenges exist to attract and/or retain providers; and
- Any suggestions on how the rate setting process could be improved at their Division.

In addition to collecting this feedback, the B&A team requested and received individual claim-level detail for services that are billed by providers to the Delaware Medicaid Enterprise System (DMES). Within DMES, information is collected and stored on all services delivered by the Division of Medicaid and Medical Assistance (DMMA) as well as the majority of services delivered through waivers administered by Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) and the Division of Developmental Disabilities Services (DDDS). Some, but not all, of the services delivered by the Division of Substance Abuse and Mental Health (DSAMH) are also stored in the DMES. The split between what is stored and what is not stored in DMES for DSAMH services is whether or not the client is Medicaid-eligible. The service-level data for clients not eligible for Medicaid who receive services from DSAMH was not readily available for this study. Also, the data from other Divisions for non-Medicaid services is not typically captured at the individual client-service level. Therefore, this data is not reported on at that level in this report.

The service-level data stored in the DMES includes services delivered in both the fee-for-service and the managed care delivery systems. Although managed care organizations (MCO) pay providers directly (as opposed to the State doing so), the MCOs are required to submit these paid claims to the DMES on a regular basis.

B&A reviewed data from DMES over a three-year period to ensure that there were not any material changes in the data reported by year. B&A found none. Therefore, throughout this report, B&A reports on the most recent year of utilization available (State Fiscal Year, or SFY, 2019). The DMES data was delivered to B&A in January 2020. This allows for a minimum six-month period to allow time for claims during this service period to be submitted by providers to the State/the MCOs and for the MCOs to submit to the DMES.

Methodology Used to Aggregate Services

For medical services and waiver services that are submitted to DMES, DMMA groups services into categories for purposes of tracking and to report to CMS in order to claim the federal matching percentage of total expenditures. B&A used the State's category of service variable to group services for this report as well. In some cases, multiple categories of service were grouped together if the services in these categories are paid using the same rate methodology.

In Section V of this report, the categories of service are displayed that represent the services for which the DMMA is responsible for. As a whole, these are considered Medicaid non-waiver services. In Section

VI of this report, the categories of service are displayed for home- and community-based services (HCBS) which includes Medicaid waivers. These services include those that are the responsibility of DMMA and Divisions other than the DMMA.

The categories of service included in Section V of the report include the following:

Exhibit 2
Categories of Service Displayed in Section V of the Report

Major Section	Sub-Section
Acute Care	Inpatient Hospital
Acute Care	Skilled Nursing Facilities and Assisted Living Facilities
Acute Care	Institutions for Mental Disease aka Psychiatric Hospitals
Acute Care	Home Health Services except Private Duty Nursing
Acute Care	Hospice Care
Outpatient Facility Care	General Acute Outpatient Hospital
Outpatient Facility Care	Ambulatory Surgical Centers
Outpatient Facility Care	End Stage Renal Disease (Dialysis) Services
Clinic Services	Federally Qualified Health Centers
Professional Services	Evaluation and Management Services (general office visits)
Professional Services	Procedure (specialty) Services
Ancillary Services	Physician-Administered Drugs
Ancillary Services	Independent Laboratory and Radiology
Ancillary Services	Durable Medical Equipment, Prosthetics and Orthotics
Substance Use Disorder	SUD Services Delivered in an Outpatient Setting
Substance Use Disorder	SUD Services Delivered in a Residential Treatment Setting
Other Medicaid Services	Children's Dental Services
Other Medicaid Services	Vision and Hearing Services
Other Medicaid Services	Emergency (Ambulance) and Non-Emergency Transportation
Other Medicaid Services	Private Duty Nursing

It was agreed with DHSS Core Team that pharmacy would be excluded from this study.

The categories of service included in Section VI of the report include the following:

Exhibit 3
Categories of Service Displayed in Section VI of the Report

HCBS Services Delivered by MCOs in Medicaid Managed Care (PLUS Program)
HCBS Services Delivered by the Division of Developmental Disabilities Services
HCBS Services Delivered by the Division of Substance Abuse and Mental Health (PROMISE Program)
Children's Behavioral Health Services Administered by the Department of Children, Youth and their Families
School Based Health Services

Within each category of service, B&A computed statistics common to all categories such as the following:

- Total Expenditures
- The percentage of the total Medicaid budget (inclusive of waivers) for this category of service
- Federal Share and State Share of Expenditures
- Total individuals using this service in SFY 2019 and percent of the total Medicaid population
- Total providers delivering the service in SFY 2019
- Top 5 services paid in SFY 2019 within the category

Other attributes are tracked for each category of service such as:

- The last time that the rate(s) for this category of service were updated by DHSS
- If there is a Medicare-equivalent rate available for the category of service
- If yes, the estimated percentage of Medicare's rate paid by DHSS
- Options for modernizing the rate methodology for the category of service
- Options for adding a value-based component for the category of service

Walk Through of the Dashboard for Medicaid Services

In this section, we provide more details on what is shown on in the dashboard reports that appear in Sections V and VI. There are four main sections shown on each dashboard:

- General Information (colored in blue)
- Information Related to Rate Setting Methodology (colored in peach)
- Information Related to Value-Based Methodology (colored in green, Section V only)
- Average Payment Per Unit for the Top Five Revenue Codes or Procedures (colored in yellow)

General Information

The General Information section is divided into:

- Expenditure Information on State Fiscal Year 2019 Incurred Services
- Population Information

In the first sub-section, the information for each service category is shown tabulated for total expenditures for SFY 2019 services (in millions) and a breakdown between the federal and state share of these dollars. The information is footnoted for the federal share because DHSS may receive different levels of federal matching dollars for different services and different categories of Medicaid enrollees. For example, the expenditures incurred for children enrolled in the State's Title XIX Children's Health Insurance Program have a higher federal match percentage than other children in Medicaid. As a conservative estimate, the federal share of expenditures shown is the minimum amount of federal matching dollars (i.e., the lowest federal match rate). Conversely, the state share of expenditures shown is the maximum amount that the state could potentially pay out.

For context, the total dollars for the service category are shown as a percentage of the total Medicaid budget on the right side in this section.

In the second sub-section, information is shown related to the number of Medicaid beneficiaries who used this service category (left side) and the number of providers who delivered the service (right side). It should be noted that, for some categories, the number of providers is not a unique count. Rather, it is a count of unique provider locations. This is an artifact of how providers are tracked in DMES.

Information is also shown that reports the percentage of all dollars for this service paid through the MCOs (as compared to the fee-for-service program). The percentage of the total MCO service expenditures is also shown. Note that this is not a percentage of all payments to the MCO (which are paid on a per member per month basis). Rather, it represents the percentage that this service category represents of all service payments made to providers by the two MCOs. Information on the right side gives other attributes about this service category.

GENERAL INFORMATION			
Expenditure Information on State Fiscal Year 2019 Incurred Services:			
Service Expenditures, SFY 2019 (in millions)	**$89.9**	Percent of Medicaid Service Budget (including waivers)	4.4%
Federal Share* of Expenditures (in millions)	**$51.8**	Classification: % of Medicaid Service Budget	**Medium**
State Share of Expenditures (in millions)	**$38.2**		
*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.			
Population Information:			
Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	3,057
Total Unique Users, SFY 2019	**165,335**	Total Providers per 1,000 Users, SFY 2019	18.5
Classification: % of Total Population Served	**High**	Classification: Provider Base	**Low**
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**97.2%**		
Percent of MCO's Service Expenditures	5.5%	Number of Provider Specialties in Category	168
Classification: % of MCO Expenditures	**Medium**		

Information Related to Rate Setting Methodology

In this section of the dashboard, an overview of DHSS rate methodology is described. Information on the last rate update is shown and an indication if there is an equivalent rate (or rates) established by CMS in the Medicare program. If yes, it is reported if DHSS uses the Medicare methodology and an estimate as to the percentage of Medicare's rate.

Options for potential ways to modernize the rate setting methodology are summarized. A key component to updating a rate methodology is the availability of provider cost data. The status of cost data is also reported. For some services such as hospitals and nursing facilities, cost data is readily available because these providers are required to submit a cost report to CMS for Medicare once per year. For other providers such as physicians, an annual cost report is not required.

INFORMATION RELATED TO RATE SETTING METHODOLOGY			
Overview of Current Rate Methodology			
DHSS pays 100% of Medicare's resource-based, relative-value system (RBRVS) for E&M codes. Updated annually. Unlike other services, non-physician clinician rates for primary care are not discounted based on place of service. There are two rates on file--one for facilities (billed by a hospital), one for non-facilities (billed by a physician practice).			
Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**78**	Does the State use this cost data to inform rate?	N/A
Options for modernizing the methodology			**Low**
Nothing specifically			

Information Related to Value-Based Methodology

In this section of the dashboard, B&A reports on whether or not DHSS uses a value-based component in the rate setting methodology for this service category. If yes, a brief description of this methodology is provided. An assessment is made as to the level of opportunity there may be to add in a value-based component. As reported in Section II, CMS has a value-based component in some rate schedules, but not all. If the assessment showed either a medium or high level of opportunity, then a brief description of the options that may be available for this service category is described.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY			
Does the State use value-based methods as part of these payments?	Yes	Level of opportunity to modernize current methodology	**Medium**
A description of those methods include:			
The State is providing per member, per month payments for care management to primary care physicians.			
Options for adding a value-based component (if level of opportunity is rated Medium or High above)			
As detailed in the Delaware State Innovation Model (SIM) Final Report (2015-2019), Delaware supported primary care practice transformation and behavioral health integration, which could serve as the basis for development of value-based components.			

Average Payment Per Unit for the Top Procedures

Depending upon the service category, the dashboard reports show either the most common rates paid to providers or the rates for the top procedure codes billed. Some providers such as hospitals (for inpatient stays) and nursing homes have rates that are specific to each provider. In this instance, the provider-specific rates or summary information about these rates is shown.

Other provider categories share the same rate and are instructed to bill common procedural technology (often referred to as *procedure codes* or *CPT codes*). CPT codes are all numeric and are referred to as Level I codes. The Level II codes are called Healthcare Common Procedure Coding System (often shortened to *HCPCS* and called "hick pics"). These codes are alphanumeric and include non-physician services such as ambulance and other transportation, medical equipment, supplies and Medicaid waiver services. Both the CPT and HCPCS lists are maintained by the American Medical Association.

When top procedures are shown, the code is displayed with a short descriptor. The percentage that this revenue code or procedure represents of all expenditures in the category is shown along with the total expenditures in dollars. The DHSS rate is shown along with the average paid amount per unit in both fee-for-service (FFS) and by the MCOs in managed care is also shown. As mentioned previously, the average payment made by the MCOs may differ from FFS because of each MCO's unique contract negotiations with providers. The average payment per unit for FFS may also vary from what is shown on the FFS rate schedule if there are payments made to offset the published rate that is "allowed" to be made.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Non-Facility Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Office or other outpatient visit, established patient, 25 minutes	99214	30.6%	$27,529,595	$109.85	$107.80	$106.73
Office or other outpatient visit, established patient, 15 minutes	99213	29.4%	$26,457,063	$75.06	$72.89	$72.58
Office or other outpatient visit, new patient, 45 minutes	99204	6.0%	$5,372,108	$166.35	$163.75	$172.00
Office or other outpatient visit, new patient, 30 minutes	99203	5.7%	$5,117,135	$109.66	$108.18	$115.25
Office or other outpatient visit, established patient, 40 minutes	99215	4.1%	$3,714,742	$147.20	$143.37	$159.20

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which differs from the standard rate.

SECTION IV: METHOD OF ASSESSING CURRENT DHSS RATE METHODOLOGIES

Methodology

In Section III, the different sections of the dashboard reports created for each service were introduced. Within each section, there were items that had a color coding with a value shown of "Low", "Medium" or "High". In total, six of these measures are displayed on each dashboard report.

The six measures are intended to provide a way for policy-makers to guide DHSS in the prioritizing of areas for future rate development. Each measure represents a domain that contributes to determining the level of priority. The six domains are as follows:

- **Spending, Percent of Total Budget.** When evaluating rates, it is important to understand how much a given rate schedule impacts total expenditures. Changes to individual rate schedules may have very different overall budgetary impacts. Measure #1, therefore, assesses the percentage of spending in the service category as a percentage of the total Medicaid budget.

- **Spending, Percent of Managed Care Spending.** Similar to the first domain, the percentage of expenditures as it relates to service spending by the MCOs is a key indicator. Measure #2 assesses the percentage spending in the service category as a percentage of total MCO spending. Measure #2 will differ from Measure #1 because not all Medicaid services are delivered by the MCOs in its contract with DHSS. For example, the MCOs do not pay for waiver services.

- **Usage Volume.** Similar to spending, it is important to understand the overall volume of use among the eligible population for a given service category. If the service is used by very few beneficiaries, the relative necessity for updates to the rate methodology may not be as high as a service category used by a majority of beneficiaries. Measure #3 assesses the percentage of the eligible population who used the service in SFY 2019.

- **Access to Providers**. The level of access to care and the provider base willing to deliver a service may be an indicator of payment adequacy. In other words, if there are providers in the state that deliver a service but they are not enrolled as a provider with Medicaid, this may be because the Medicaid rate is too low for them to consider enrolling. For other services, it is not that providers are available but unwilling to enroll, but rather there are few providers in the state to start with. A low base of providers to choose from means a greater sensitivity to provider accessibility. Measure #4 assesses the number of providers per 1,000 Medicaid users. The lower the number, the more likely that there may be access to care challenges.

- **Methodology Opportunity.** Methods for determining provider payment rates have evolved over time. CMS has actually made many fundamental changes in the last 10 years to a number of reimbursement methodologies in an effort to promote efficiency. State Medicaid Agencies often adopt Medicare or Medicare-like methodologies for basing their payment methodologies where there is service overlap. Or, Medicaid agencies will borrow methodologies from each other, particularly for those services that Medicare does not cover. Measure #5 is B&A's assessment of DHSS's opportunity to modernize its payment methodology for the service category vis a vis how Medicare or other State Medicaid Agencies have developed their own rates.

- **Value-based Opportunity.** In recent years, there is an increased focus on linking a proportion of healthcare service payments to quality of care. There are a number of generally accepted approaches to value-based purchasing the nature of which vary by service category. Measure #6 is B&A's assessment of DHSS's opportunity to add a value-based component to the reimbursement methodology for the service category.

For each of the six measures, B&A assigned a level of low, medium or high. B&A defined the ranges for each measure in consultation with DHSS Core Team assigned to develop this report. For the first four measures, the data used to make the assessment comes directly from computations made by B&A using DMES data. The scores assigned to Measures #5 and #6 are subjective and based on the B&A team's experience in setting or reviewing rates and rate methodologies for other state health and social services agencies and our experience with the Medicare reimbursement methodologies. The definitions for scoring within each measure are shown in Exhibit 4 below. The color coding ties to the section of the dashboard where each measure appears.

Exhibit 4
Definitions of the Scores Given Based on Criteria Specific to Each Measure

	Measure	Low	Medium	High
1	Percent of Medicaid Service Budget	Expenditures for the service category represent < 2% of the total budget for Medicaid services.	Expenditures for the service category represent 2.01 to 7.0% of the total budget for Medicaid services.	Expenditures for the service category represent > 7.01% of the total budget for Medicaid services.
2	Percent of Managed Care Spending	Expenditures for the service category represent < 2% of the total MCO service spending.	Expenditures for the service category represent 2.01 to 7.0% of the total MCO service spending.	Expenditures for the service category represent > 7.01% of the total MCO service spending.
3	Percent of Users of the Service	Users of the service category represent < 2.0% of the total Medicaid population.	Users of the service category represent 2.1 to 10.0% of the total Medicaid population.	Users of the service category represent >10.0% of the total Medicaid population.
4	Provider Access	Number of providers per 1,000 is 15.0 or greater.	Number of providers per 1,000 is between 5.01 and 14.99.	Number of providers per 1,000 is 5.0 or fewer.
5	Opportunity to Modernize Payment System	The methodology used today to set the rate is considered "cutting edge" or more innovative than how other entities pay.	The methodology used today to set the rate is considered within the norm of how other entities pay for the service.	The methodology used today to set the rate is outdated or not within the norm of how other entities pay for the service.
6	Opportunity to Add Value-Based Component	There are limited known methods in the field that could be used to add a value-based component or it is not practical for this service to do so.	There may be opportunities to add a value-based component to the rate methodology, but there is not a known method that has been tested in the field. It would need to be a Delaware-defined solution.	There are known methods in the field that could be easily leveraged to add a value-based component to the rate methodology.

Using this methodology, each measure rated low is given a score of 1; each measure rated medium is give a score of 2; and each measure rated high is given a score of 3. Therefore, 18 maximum points are available. Any service categories with a score close to 18 have the greatest opportunity for rate modernization vis a vis other service categories.

Exhibit 5 on the next page shows the results of this process for non-waiver Medicaid services. Among the 20 service categories examined, seven had a score greater than 10. Three categories had a score of 14 or greater (inpatient hospital, outpatient hospital and nursing facilities).

Exhibit 5
Scores Assigned to Each Measure by Service Category to Obtain Final Prioritization Score

Dashboard Number	Service Category	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
1.1	General Acute Care Inpatient Hospital	High	High	Medium	Medium	High	High	16
1.2	Skilled Nursing Facilities and Assisted Living Facilities	High	High	Low	High	High	High	16
1.3	Psychiatric Hospitals	Low	Medium	Low	High	Medium	High	12
1.4	Home Health Agencies	Low	Medium	Low	High	Medium	High	12
1.5	Hospice Care	Low	Low	Low	High	Low	Low	8
2.1	General Acute Care Outpatient Hospital	High	High	High	Medium	High	High	17
2.2	Ambulatory Surgery Centers (ASCs)	Low	Low	Low	Medium	Low	Low	7
2.3	End Stage Renal Disease (ESRD) Services, Health Centers other than FQHCs	Low	Low	High	High	Low	Low	10
3.1	Federally Qualified Health Centers (FQHCs)	Low	Low	Medium	Medium	Low	Medium	9
4.1	Evaluation and Management Services (primarily office visits)	Medium	Medium	High	Low	Low	Medium	11
4.2	Procedure Services	High	High	High	Low	Low	Medium	13
5.1	Physician-Administered Drugs	Low	Low	Medium	Low	Low	Low	7
5.2	Independent Laboratory and Radiology	Low	Low	High	Low	Low	Medium	9
5.3	Durable Medical Equipment, Prosthetics and Orthotics	Low	Low	Medium	Low	Low	Medium	8
6.1	Substance Use Disorder Services, Outpatient	Low	Low	Medium	Low	Low	Medium	8
6.2	Substance Use Disorder Services, Residential	Low	Low	Low	Low	Medium	Medium	8
7.1	Children's Dental Services	Medium	Low	High	High	Low	Medium	12
7.2	Vision and Hearing Services	Low	Low	Medium	Medium	Low	Low	8
7.3	Non-Emergency Medical Transportation and Emergency Transportation (Ambulance)	Low	Low	Medium	Medium	Low	Low	8
7.4	Private Duty Nursing	Low	Low	Low	Low	Medium	Low	7

SECTION V: FINDINGS RELATED TO SERVICES PAID BY THE DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Introduction

In Section V, the summary reports for services delivered by the Division of Medicaid and Medical Assistance are presented. The design of each of the reports is the same for ease of review.

Services have been organized into seven major categories. Most of these major categories contain multiple summary reports behind them. The summary reports are segmented based on services that are similar in nature or that share a common rate schedule. The major categories are:

- Section 1: Acute Care
- Section 2: Outpatient Facility Care
- Section 3: Clinic Services
- Section 4: Professional Services
- Section 5: Ancillary Services
- Section 6: Mental Health and Substance Use Disorder Services
- Section 7: Other Medicaid Services

An introduction page is provided for each of these seven categories. In this introduction, the assessment scores that were assigned to each service under the major category are shown for convenience. [The assessment scores are also shown on each service summary page.] The highlights of the areas of greatest opportunity for DHSS to either modernize rate setting methodologies or to add value-based components to the methodology are also cited.

Independent Study of Rate Methodologies for Services Delivered by the Divisions within the Delaware Department of Health and Social Services

Section 1: Acute Care

Section 1 includes five summary reports:

1.1 General Acute Care Inpatient Hospital Services
1.2 Skilled Nursing Home Facilities and Assisted Living Facilities
1.3 Institutions for Mental Disease (IMDs) (Psychiatric Hospitals)
1.4 Home Health Agencies except Private Duty Nursing
1.5 Hospice Care

Within this section, the assessment scores show that the recommendation for highest-priority related to rate reform or value-based opportunities are in the areas of inpatient hospital and skilled nursing facilities.

Dashboard Number	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
1.1	High	High	Medium	Medium	High	High	16
1.2	High	High	Low	High	High	High	16
1.3	Low	Low	Low	High	Medium	High	11
1.4	Low	Low	Low	High	Medium	High	11
1.5	Low	Low	Low	High	Low	Low	8

Discussion

The area of greatest opportunity to update rates is for inpatient hospital and nursing facility services. The inpatient hospital rates were last updated in 2008. Currently, rates are set on a per discharge basis without regard to the acuity of the patient. Medicare and most State Medicaid Agencies pay for inpatient services on a per discharge (i.e. multiple day) basis and pay different rates based on the type of service and acuity of the patient. This is achieved by assigning cases to a diagnostic related group, or DRG.

In a DRG payment system, it is also easier to track the prevalence of readmissions by examining if a patient was readmitted for the same or similar reason (i.e., the same DRG) or for an unrelated reason. The Medicare program reduces hospital payments if the readmission rate at the hospital exceeds certain targets. Some Medicaid programs either discount payments on readmission or, at minimum, track and trend readmission rates that are publicly reported.

The other area of high opportunity is the Skilled Nursing Facility rates. These rates have not undergone a full reset using current costs since 2007. Rates are set on a per diem basis which is the industry standard. DHSS has also set its per diem rates to reflect the staffing resource intensity (patient acuity) required which is also the industry standard. Medicare made a fundamental change in the tool that it uses to create patient acuity scores in 2019. The previous tool, which was used by the majority of Medicaid agencies, will not be supported by CMS beginning in October 2020. There is a high degree of opportunity to make rate setting changes in this service as soon as possible.

Both Medicare and some Medicaid agencies also utilize quality rating scores of nursing facilities. These can be used for reporting purposes only, to reward incentive payments to providers, or to cut rates for under-performing providers. DHSS does not have any of these methods in place today.

CATEGORY OF SERVICE	1	ACUTE CARE
SUB-CATEGORY OF SERVICE	1.1	General Acute Care Inpatient Hospital

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$402.6**	Percent of Medicaid Service Budget (including waivers)	19.9%
Federal Share* of Expenditures (in millions)	**$231.7**	Classification: % of Medicaid Service Budget	**High**
State Share of Expenditures (in millions)	**$170.9**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	7
Total Unique Users, SFY 2019	**20,517**	Total Providers per 1,000 Users, SFY 2019	7.7
Classification: % of Total Population Served	**Medium**	Classification: Provider Base	**Medium**
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**87.8%**		
Percent of MCO's Service Expenditures	22.3%	Number of Provider Specialties in Category	5
Classification: % of MCO Expenditures	**High**		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Inpatient rates are paid per discharge. There are two types of discharge rates: 1) a general services rate and 2) a nursery services per discharge. There are three components that comprise each discharge rate: operating, capital, and medical education. Operating payment derived from fiscal year (FY) 1992 cost reports and claims data. High cost outliers are determined if the cost of discharge exceeds 4 times the hospital operating rate per discharge. 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.

Last rate update for this service	**2009**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	No
Unit of Payment for Service	Per Discharge	What percent of Medicare rate does DHSS pay?	unknown
Is the rate(s) standard or provider-specific?	Specific	Is provider cost information readily available to inform rate?	Yes
Total Unique # of Revenue Codes	**215**	Does the State use this cost data to inform rate?	No

Options for modernizing the methodology **High**

Consider adoption of a prospective payment system (PPS) like Medicare or similar methodology using diagnosis related grouping. Tie payments of cases closer to actual costs, since the State may be paying far above costs on some cases.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? Some | Level of opportunity to modernize current methodology **High**

A description of those methods include:

As required by CMS, currently adjust payments for provider preventable conditions (PPC) and hospital acquired conditions (HAC).

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Develop a value-based framework, such as potentially preventable readmissions, to be used for holding some percent of existing payment dollars, or create additional incentive payment dollars for redistribution based on performance.

CURRENT FEE-FOR-SERVICE PER DIEMS (Note: It is not known what the managed care organizations pay the hospitals.)

Published Per Diem Rates by Hospital	Pct Spend in this Category	$$ Expenditures		FFS Rate, Per Discharge, Nursery	FFS Rate, Per Discharge, All Except Nursery
A.I. DuPont	31.4%	$126,511,389		$3,410.02	$11,064.38
Bayhealth Medical Center	4.1%	$16,601,793		$1,273.65	$3,622.14
Beebe	3.2%	$12,811,233		$1,406.60	$3,879.60
Christiana Care	32.5%	$130,797,145		$1,973.02	$8,270.22
Kent General	11.7%	$47,034,715		$1,337.55	$4,785.95
Nanticoke Memorial	1.7%	$6,969,829		$1,027.61	$3,437.90
St. Francis	4.3%	$17,138,810		$1,372.90	$4,316.66

CATEGORY OF SERVICE	1	ACUTE CARE
SUB-CATEGORY OF SERVICE	1.2	Skilled Nursing Facilities and Assisted Living Facilities

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$324.9**	Percent of Medicaid Service Budget (including waivers)	16.1%
Federal Share* of Expenditures (in millions)	**$187.0**	Classification: % of Medicaid Service Budget	**High**
State Share of Expenditures (in millions)	**$137.9**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	14
Total Unique Users, SFY 2019	**4,132**	Total Providers per 1,000 Users, SFY 2019	3.1
Classification: % of Total Population Served	**Low**	Classification: Provider Base	**High**
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**86.9%**		
Percent of MCO's Service Expenditures	17.8%	Number of Provider Specialties in Category	4
Classification: % of MCO Expenditures	**High**		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Intermediate and skilled nursing homes are paid a per diem rate. The rates have five prospectively determined components: primary patient care, secondary patient care, support services, administration, and capital cost. Two peer groups established for the primary care rate settings: Privately-owned and State-owned. The rates also vary by patient complexity. There are 32 levels in all based on patient complexity.
Rates paid to individual providers will also vary because an additional component to the facility's rate is based on payments that providers make through a tax paid to the state.

Last rate update for this service	**2007**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	No
Unit of Payment for Service	Per Diem	What percent of Medicare rate does DHSS pay?	unknown
Is the rate(s) standard or provider-specific?	Specific	Is provider cost information readily available to inform rate?	Yes
Total Unique # of Revenue Codes	**52**	Does the State use this cost data to inform rate?	No

Options for modernizing the methodology **High**

Consider adopting CMS Patient Driven Payment Model (PDMP) patient classification system for case mix adjustment purposes and the Medicare Skilled Nursing Facility (SNF) prospective payment system as the basis for an updated payment model.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No | Level of opportunity to modernize current methodology **High**

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Develop a value-based framework, such as the Medicare SNF value-based payment program, by committing either a portion of the per diem payment or incentive dollars to be distributed to providers based on perfornance.

CURRENT FEE-FOR-SERVICE PER DIEMS (Note: It is not known what the managed care organizations pay the facilities.)

Published Per Diem Rates by Nursing Facility	Per Diem Rate
The per diem rates vary across the 38 facilities and the 32 levels in a facility, so there are 1,216 unique per diems in all. Refer to Appendix B for details.	
Minimum Value across all Nursing Facilities	$232.51
Median Value across all Nursing Facilities	$299.48
Maximum Value across all Nursing Facilities*	$442.07

*There is an exception to this for a single facility that has a separate rate for ventilator-dependent residents.

CATEGORY OF SERVICE	1	ACUTE CARE
SUB-CATEGORY OF SERVICE	1.3	Institutions for Mental Disease (IMDs) aka Psychiatric Hospitals

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$36.0**	Percent of Medicaid Service Budget (including waivers)	1.8%
Federal Share* of Expenditures (in millions)	**$20.7**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$15.3**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	7
Total Unique Users, SFY 2019	**2,986**	Total Providers per 1,000 Users, SFY 2019	1.0
Classification: % of Total Population Served	Low	Classification: Provider Base	High
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**92.6%**		
Percent of MCO's Service Expenditures	2.1%	Number of Provider Specialties in Category	1
Classification: % of MCO Expenditures	Medium		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Defaults to Medicare's methodology. Paid using a prospectively set per diem rate based on annual reported allowable Medicare cost. This is equal to previous year's total allowable cost/total # of patient bed days. The rate is recalculated annually (reimbursement year = Oct. 1-Sept. 30) and the per diem rate is not cost settled, but is limited to the upper payment limit. The per diem is equal to 93% of Medicare Inpatient Psychiatric Facility prospective payment system rate for Delaware.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Diem	What percent of Medicare rate does DHSS pay?	93%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	Yes
Total Unique # of Revenue Codes	**16**	Does the State use this cost data to inform rate?	No

Options for modernizing the methodology — Medium

Consider adoption of a prospective payment system (PPS) like Medicare or similar methodology using diagnosis related grouping.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments?	No	Level of opportunity to modernize current methodology	High

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Develop a value-based framework, such as potentially preventable readmissions, to be used for holding some percent of existing payment dollars, or create additional incentive payment dollars for redistribution based on performance.

CURRENT FEE-FOR-SERVICE PER DIEMS (Note: It is not known what the managed care organizations pay the hospitals.)

Published Per Diem Rates	Per Diem Rate
New Castle County, 93% of Medicare	$815.70
Kent County, 93% of Medicare	$738.14
Sussex County, 93% of Medicare	$704.39
Rate for Partial Hospitalization, 100% of Medicare rate, all counties	$233.52

CATEGORY OF SERVICE	1	ACUTE CARE
SUB-CATEGORY OF SERVICE	1.4	Home Health Agencies

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$38.6**	Percent of Medicaid Service Budget (including waivers)	1.9%
Federal Share* of Expenditures (in millions)	**$22.2**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$16.4**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	82
Total Unique Users, SFY 2019	**3,985**	Total Providers per 1,000 Users, SFY 2019	0.8
Classification: % of Total Population Served	Low	Classification: Provider Base	High
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**88.0%**		
Percent of MCO's Service Expenditures	2.1%	Number of Provider Specialties in Category	6
Classification: % of MCO Expenditures	Medium		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

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. Rates are arrayed to determine the 75th percentile value among enrolled Delaware Medicaid providers for each procedure code. Rates are inflated the CMS Home Health Market Basket index when funds are available.

Last rate update for this service	**2015**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	Yes	Does the State use the Medicare methodology?	No
Unit of Payment for Service	Per Visit	What percent of Medicare rate does DHSS pay?	unknown
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	Yes
Total Unique # of CPT/HCPCS Codes	**51**	Does the State use this cost data to inform rate?	No

Options for modernizing the methodology — Medium

Move to a methodology similar to one employed by Medicare (see below) that factors in the complexity and needs of the patient.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments?	No	Level of opportunity to modernize current methodology	High

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

An episodic bundled rate could be developed to discourage over-utilization on a per visit basis. Medicare pays for home health based on a 60-day episode of care. There are provisions for a different type of payment if the patient only needs a few days of care out of the 60 days.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE SERVICES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Nursing care in the home by an LPN, per hour	S9124	32.3%	$12,463,473	$46.14	not used	$43.31
Nursing care in the home by an RN, per hour	S9123	29.2%	$11,277,661	$51.50	not used	$46.60
Skilled nursing in the home by an RN, per 15 min	G0299	19.6%	$7,542,738	$40.83	$39.53	$39.36
Home heath services by an aide, per 15 min	G0156	5.8%	$2,232,256	$8.72	$8.47	$6.22
Physical therapist services in the home, per 15 min	G0151	5.6%	$2,154,947	$40.98	$38.91	$37.62

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	1	ACUTE CARE
SUB-CATEGORY OF SERVICE	1.5	Hospice Care

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$2.8**	Percent of Medicaid Service Budget (including waivers)	0.1%
Federal Share* of Expenditures (in millions)	**$1.6**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$1.2**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	21
Total Unique Users, SFY 2019	**251**	Total Providers per 1,000 Users, SFY 2019	0.0
Classification: % of Total Population Served	Low	Classification: Provider Base	High
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**98.2%**		
Percent of MCO's Service Expenditures	0.2%	Number of Provider Specialties in Category	2
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Reimbursement made at one of four predetermined rates for each day of hospice care. 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, and general inpatient care. No Medicare reimbursement cap applied for Delaware Medicaid hospice providers.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Diem	What percent of Medicare rate does DHSS pay?	100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**9**	Does the State use this cost data to inform rate?	N/A
Options for modernizing the methodology			Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments?	No	Level of opportunity to modernize current methodology	Low

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

CURRENT FEE-FOR-SERVICE PER DIEMS (Note: It is not known what the managed care organizations pay the providers.)

Published Per Diem Rates	Per Diem Rate
Routine home care (days 1 through 60)	$194.50
Routine home care (days 61 and after)	$153.72
Continuous home care ($58.15 per hour x 24 hours)	$1,395.63
Inpatient respite care	$451.10
General inpatient care	$1,021.25

Section 2: Outpatient Facility Care

Section 2 includes three summary reports:

2.1 General Acute Care Outpatient Hospital
2.2 Ambulatory Surgery Centers (ASCs)
2.3 End Stage Renal Disease (ESRD) Services, Health Centers other than FQHCs

Within this section, the assessment scores show that the recommendation for highest-priority related to rate reform or value-based opportunities are in the area of outpatient hospital general acute care.

Dashboard Number	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
2.1	High	High	High	Medium	High	High	17
2.2	Low	Low	Low	Medium	Low	Low	7
2.3	Low	Low	High	High	Low	Low	10

Discussion

DHSS uses a modification of the way that Medicare and some other Medicaid agencies pay for outpatient hospital services. Since 2000, Medicare has paid using its Outpatient Prospective Payment System (OPPS). In this rate methodology, services are grouped into categories similar to what was described for inpatient hospital services. Whereas the inpatient system groups based on diagnosis, Medicare's outpatient system groups based on procedures. Medicare has continued to increase the complexity of this payment system over time in an effort to achieve the greatest value. For example, ancillary or incidental services are not paid separately, but rather, are rolled into the payment for more significant procedures. Other services that are delivered in the same visit, such as two x-ray exams, are discounted to account for the economies of scale that are achieved to do them at the same time.

Although DHSS has defined rates for many outpatient hospital services, there is a high degree of opportunity to gain efficiencies to migrate to a rate methodology more akin to Medicare's OPPS. Rates have not been updated since 2009. Further, some services are still paid by DHSS using a percentage of billed charges. This is both highly variable across hospitals (each hospital is paid differently for the same service) and not cost-efficient to the State.

DHSS uses Medicare's methodology to pay for Ambulatory Surgical Centers (ASCs) and updates these rates annually. For other services in this section, although there is opportunity to add sophistication to the rate methodologies used (e.g., end stage renal disease services), the overall expenditures relative to other services is low.

CATEGORY OF SERVICE	2	OUTPATIENT FACILITY CARE
SUB-CATEGORY OF SERVICE	2.1	General Acute Care Outpatient Hospital

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$341.3**	Percent of Medicaid Service Budget (including waivers)	16.9%
Federal Share* of Expenditures (in millions)	**$196.4**	Classification: % of Medicaid Service Budget	**High**
State Share of Expenditures (in millions)	**$144.9**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	19
Total Unique Users, SFY 2019	**109,162**	Total Providers per 1,000 Users, SFY 2019	7.3
Classification: % of Total Population Served	**High**	Classification: Provider Base	**Medium**
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**95.4%**		
Percent of MCO's Service Expenditures	20.5%	Number of Provider Specialties in Category	2
Classification: % of MCO Expenditures	**High**		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Prospective flat visit rate for four types of outpatient services: Emergency Department (emergencies and non-emergencies), clinic, and labor/delivery room. For all other services, a hospital-specific cost-to-charge ratio (CCR) is applied that pays by multiplying the charges billed on the claim by the CCR. The CCR values are specific to defined groupings of services and are specific to each hospital in the state. Lab services delivered in the outpatient hospital setting are paid by using the DMMA lab fee schedule. The visit rates are based on hospital cost report data (when the rates were set in 2009) and are indexed forward using the CMS IPPS index. Hospital-specific CCRs were set using 1992 costs.

Last rate update for this service	**2009**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	No
Unit of Payment for Service	Per Visit	What percent of Medicare rate does DHSS pay?	unknown
Is the rate(s) standard or provider-specific?	Specific	Is provider cost information readily available to inform rate?	Yes
Total Unique # of CPT/HCPCS Codes	**180**	Does the State use this cost data to inform rate?	No

Options for modernizing the methodology **High**

Adopt a prospective payment system approach using either Medicare's Outpatient Prospective Payment Sytem (OPPS) or 3M's Enhanced Ambulatory Patient Grouping (EAPG) methodology.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No | Level of opportunity to modernize current methodology **High**

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Develop value-based framework for holding some percent of either existing or create additional incentive payment dollars aside for use in redistribution based on performance. Metrics could be selected from Medicare's Hospital Outpatient Quality Reporting Program.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE SERVICES

Short Descriptor of Top Revenue Codes Billed	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Emergency Room-General Classification	450	16.1%	$55,052,435	Hospital-specific visit rates or CCRs	$191.71	$349.23
Drugs Requiring Specific Identification-Drugs Requiring Detailed Coding	636	14.3%	$48,794,309		$875.49	$613.32
Operating Room Services-General Classification	360	11.3%	$38,649,581		$2,633.75	$2,536.50
Medical/Surgical Supplies and Devices-Other Implants	278	4.6%	$15,720,923		$1,020.23	$3,984.57
Laboratory-Chemistry	301	4.6%	$15,657,125		$68.47	$135.44

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	2	OUTPATIENT FACILITY CARE
SUB-CATEGORY OF SERVICE	2.2	Ambulatory Surgery Centers (ASCs)

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$8.5**	Percent of Medicaid Service Budget (including waivers)	0.4%
Federal Share* of Expenditures (in millions)	**$4.9**	Classification: % of Medicaid Service Budget	**Low**
State Share of Expenditures (in millions)	**$3.6**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	32
Total Unique Users, SFY 2019	**4,773**	Total Providers per 1,000 Users, SFY 2019	6.7
Classification: % of Total Population Served	**Low**	Classification: Provider Base	**Medium**
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**98.3%**		
Percent of MCO's Service Expenditures	0.5%	Number of Provider Specialties in Category	2
Classification: % of MCO Expenditures	**Low**		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Delaware Medicaid reimburses 95% of the Medicare calculated ASC rates as reimbursement. Rates vary by three geographic regions.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	95%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**763**	Does the State use this cost data to inform rate?	N/A
Options for modernizing the methodology			**Low**

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments?	No	Level of opportunity to modernize current methodology	**Low**

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019 (New Castle Co.)	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Laparoscopic bariatric procedure, longitudinal gastrectomy	43775	13.0%	$1,105,000	not listed	$0.00	$18,416.67
Esophagogastroduodenoscopy, with biopsy	43239	4.9%	$419,062	$401.64	$339.94	$311.01
Extracapsular cataract removal with insertion of intraocular lens prosthesis	66984	4.6%	$391,927	$1,000.61	$852.99	$1,019.29
Colonoscopy with removal of tumor, polyp or lesion	45385	2.9%	$243,222	$516.75	$475.88	$431.14
Colonoscopy, diagnostic procedure	45378	2.7%	$230,245	$392.86	$358.88	$334.54

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	2	OUTPATIENT FACILITY CARE
SUB-CATEGORY OF SERVICE	2.3	End Stage Renal Disease (ESRD) Services, Health Centers other than FQHCs

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$18.0**	Percent of Medicaid Service Budget (including waivers)	0.9%
Federal Share* of Expenditures (in millions)	**$10.3**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$7.6**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	238
Total Unique Users, SFY 2019	**41,614**	Total Providers per 1,000 Users, SFY 2019	0.8
Classification: % of Total Population Served	High	Classification: Provider Base	High
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**88.0%**		
Percent of MCO's Service Expenditures	1.0%	Number of Provider Specialties in Category	19
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Paid at 100% of the applicable Medicare rate. The rate is paid on a per treatment basis. There may be modifications to the standard rate based on locality (a local wage adjustment) or for low-volume providers.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Visit	What percent of Medicare rate does DHSS pay?	100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**30**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Low

Adopt Medicare methodology.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Low

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

CURRENT FEE-FOR-SERVICE PER VISIT RATES (Note: It is not known what the managed care organizations pay the providers.)

Published Per Visit Rate	Per Diem Rate
Effective October 1, 2019, the base rate is $239.33	
Wage adjustment* for Kent County	0.9921
Wage adjustment for New Castle County	1.1279
Wage adjustment for Sussex County	0.9330
*The national average wage adjustment is 1.0000.	

Independent Study of Rate Methodologies for Services Delivered by the Divisions within the Delaware Department of Health and Social Services

Section 3: Clinic Services

Section 3 includes only one summary report:

3.1 Federally Qualified Health Centers (FQHCs)

The assessment scores for FQHCs are shown below.

Dashboard Number	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
3.1	Low	Low	Medium	High	Low	Medium	10

Discussion

The term Federally Qualified Health Center is a specific designation given by the Centers for Medicare and Medicaid (CMS) to qualifying clinics. Although DHSS expenditures for FQHCs are relatively low compared to other service categories, FQHCs serve as "safety net" providers in the Medicaid program. They serve as the front line for primary care visits, immunizations, prenatal visits, pharmacy and—for those that have the infrastructure—dental visits. As part of this CMS designation, FQHCs are obligated to treat all that come to their doors.

By nature of their mission and model, CMS allows some protections to FQHCs when it comes to rates. Each FQHC is paid a rate for the "encounter"—whatever service that might entail when the patient arrives. The encounter rate is specific to each FQHC. The rate is indexed annually by the Medicare Economic Index (an inflation factor to increase the rate). Since legislation passed by Congress in 2000, FQHCs may also select an alternative payment model (APM) rate if it is more advantageous to them. Unlike the annual inflation method which uses historic costs from the FQHC, State Medicaid Agencies have discretion as to how this APM rate is designed.

DHSS is following the rules set by CMS related to options to pay FQHCs. Although there may be other options as to how to design the APM method for rate setting, this is a lower priority vis a vis other Medicaid services.

CATEGORY OF SERVICE	3	CLINIC SERVICES
SUB-CATEGORY OF SERVICE	3.1	Federally Qualified Health Centers (FQHCs)

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$15.7**	Percent of Medicaid Service Budget (including waivers)	0.8%
Federal Share* of Expenditures (in millions)	**$9.0**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$6.7**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	144
Total Unique Users, SFY 2019	**19,303**	Total Providers per 1,000 Users, SFY 2019	7.5
Classification: % of Total Population Served	Medium	Classification: Provider Base	Medium
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**95.7%**		
Percent of MCO's Service Expenditures	0.9%	Number of Provider Specialties in Category	31
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Two methodology options to reimburse FQHCs per-visit: 1. A prospective payment system (PPS) rate, where 100 percent of the reasonable costs based upon an average of the FQHC's 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. Wraparound payments made within 90-days of claims submission to managed care plan.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	No
Unit of Payment for Service	Per Visit	What percent of Medicare rate does DHSS pay?	unknown
Is the rate(s) standard or provider-specific?	Specific	Is provider cost information readily available to inform rate?	Yes
Total Unique # of CPT/HCPCS Codes	**20**	Does the State use this cost data to inform rate?	Yes

Options for modernizing the methodology — Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Medium

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Based on work undertaken as part of the State Innovation Model, continue exploration of a value-based alternative payment methodology for FQHCs.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
FQHC visit, initial exam	G0467	38.3%	$6,011,293		$245.96	$223.61
FQHC visit, established patient	G0468	4.6%	$721,603		$219.58	$212.66
-La Red Health Center (both codes)				$236.19		
-Westside Health Inc (both codes)				$260.38		
Clinic service	T1015	32.3%	$5,063,724	not used	not used	$241.58
Drug test(s), definitive, utilizing drug identification method, 8-14 drug classes	G0481	8.4%	$1,313,200	$120.53	not used	$102.77
Drug test(s), definitive, utilizing drug identification method, 15-21 drug classes	G0482	5.1%	$803,837	$162.71	$162.71	$70.51

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

Section 4: Professional Services

Section 4 includes two summary reports:

4.1 Evaluation & Management (E&M) Services
4.2 Procedure Services

Within this section, the assessment scores show that there is some opportunity for value-based purchasing but low on modernizing the rate methodology itself:

Dashboard Number	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
4.1	Medium	Medium	High	Low	Low	Medium	11
4.2	High	High	High	Low	Low	Medium	13

Discussion

DHSS has adopted Medicare's rate methodology to pay physicians, physician assistants, nurse practitioners, and other specialty providers. This methodology, known as the Resource Based Relative Value Scale (RBRVS), pays for different types of office visits or procedures based on the amount of time spent by the medical professional with the patient, the costs borne by the provider's practice (including any medical equipment), and malpractice insurance. Each visit or procedure is "scored" using relative values to assess the magnitude of resources required. Thus, an array of over 12,000 services and procedures are given scores "relative" to each other. The scores are updated annually by CMS. Comprehensive reviews of the scores for each section (provider time, practice expense and malpractice insurance) are reviewed about once every five years by CMS in coordination with a committee from the American Medical Association.

DHSS has adopted Medicare's RBRVS payment system and makes the annual updates that CMS releases. Providers contracted with Medicaid are paid at 100% of the Medicare RBRVS rate. As a result, there is not a need for rate methodology reform per se. However, there could be opportunities related to introducing value-based components into the rates paid, such as an incentive payment for higher quality services delivered. Any value-based component would have to be designed by DHSS since there are no prevailing national standards for value-based incentives.

CATEGORY OF SERVICE	4	PROFESSIONAL SERVICES
SUB-CATEGORY OF SERVICE	4.1	Evaluation and Management Services (primarily office visits)

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$89.9**	Percent of Medicaid Service Budget (including waivers)	4.4%
Federal Share* of Expenditures (in millions)	**$51.8**	Classification: % of Medicaid Service Budget	Medium
State Share of Expenditures (in millions)	**$38.2**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	3,057
Total Unique Users, SFY 2019	**165,335**	Total Providers per 1,000 Users, SFY 2019	18.5
Classification: % of Total Population Served	High	Classification: Provider Base	Low
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**97.2%**		
Percent of MCO's Service Expenditures	5.5%	Number of Provider Specialties in Category	168
Classification: % of MCO Expenditures	Medium		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

DHSS pays 100% of Medicare's resource-based, relative-value system (RBRVS) for E&M codes. Updated annually. Unlike other services, non-physician clinician rates for primary care are not discounted based on place of service. There are two rates on file--one for facilities (billed by a hospital), one for non-facilities (billed by a physician practice).

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**78**	Does the State use this cost data to inform rate?	N/A
Options for modernizing the methodology			Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? Yes — Level of opportunity to modernize current methodology: Medium

A description of those methods include:

The State is providing per member, per month payments for care management to primary care physicians.

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

As detailed in the Delaware State Innovation Model (SIM) Final Report (2015-2019), Delaware supported primary care practice transformation and behavioral health integration, which could serve as the basis for development of value-based components.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Non-Facility Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Office or other outpatient visit, established patient, 25 minutes	99214	30.6%	$27,529,595	$109.85	$107.80	$106.73
Office or other outpatient visit, established patient, 15 minutes	99213	29.4%	$26,457,063	$75.06	$72.89	$72.58
Office or other outpatient visit, new patient, 45 minutes	99204	6.0%	$5,372,108	$166.35	$163.75	$172.00
Office or other outpatient visit, new patient, 30 minutes	99203	5.7%	$5,117,135	$109.66	$108.18	$115.25
Office or other outpatient visit, established patient, 40 minutes	99215	4.1%	$3,714,742	$147.20	$143.37	$159.20

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	4	PROFESSIONAL SERVICES
SUB-CATEGORY OF SERVICE	4.2	Procedure Services

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$168.5**	Percent of Medicaid Service Budget (including waivers)	8.3%
Federal Share* of Expenditures (in millions)	**$97.0**	Classification: % of Medicaid Service Budget	**High**
State Share of Expenditures (in millions)	**$71.5**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	4,245
Total Unique Users, SFY 2019	**167,262**	Total Providers per 1,000 Users, SFY 2019	25.4
Classification: % of Total Population Served	**High**	Classification: Provider Base	**Low**
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**96.2%**		
Percent of MCO's Service Expenditures	10.2%	Number of Provider Specialties in Category	181
Classification: % of MCO Expenditures	**High**		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Enhanced rates based on 100% of Medicare's resource-based, relative-value system (RBRVS). Updated annually. Rates are discounted based on place of service. If a Medicare fee exists for a defined covered procedure code, then Delaware will pay Psychologists at 100% of the Medicaid physician rates. 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.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Mostly
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Mostly
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**4,138**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — **Low**

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: **Medium**

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Consider adoption of value-based components, drawing upon Delaware's experience with the State Innovation Model grant, as detailed in the Delaware State Innovation Model (SIM) Final Report (2015-2019).

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Psychotherapy, 60 min with patient	90837	8.5%	$14,353,159	$135.88	$107.36	$100.69
Emergency dept visit, physician time, high severity case imminent danger	99285	4.3%	$7,294,212	$175.62	$175.79	$194.50
Emergency dept visit, physician time, high severity case not imminent danger	99284	3.9%	$6,534,775	$119.21	$119.36	$139.69
Psychotherapy, 45 min with patient	90834	3.2%	$5,457,184	$90.45	$75.73	$72.37
Emergency dept visit, physician time, moderate severity case	99283	3.2%	$5,414,095	$62.84	$62.97	$95.86

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

Section 5: Ancillary Services

Section 5 includes three summary reports:

5.1 Physician-administered Drugs
5.2 Independent Laboratory and Radiology
5.3 Durable Medical Equipment, Prosthetics and Orthotics (DMEPOS)

Physician-administered drugs are those that are not filled at a pharmacy. An example of this would be chemotherapy administered in a doctor's office. Independent lab and radiology are those providers that are not owned by a hospital, a clinic, or a doctor's office. They perform lab tests or radiology exams. Durable medical equipment, prosthetics and orthotics covers a vast array of items (as opposed to services). Some examples include wheelchairs and associated accessories; walkers, canes and crutches; enhanced nutrition; incontinence supplies; special shoes for diabetics; oxygen and oxygen devices; and orthotic devices (e.g., for spine, knee, ankle, feet).

Within this section, the assessment scores show that the priority for rate reform or value-based purchasing fairly low:

Dashboard Number	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
5.1	Low	Low	Medium	Low	Low	Low	7
5.2	Low	Low	High	Low	Low	Medium	9
5.3	Low	Low	Medium	High	Low	Medium	10

Discussion

The services referenced in this section have either been updated fairly recently by DHSS (physician-administered drugs) or are updated on a regular basis (lab, radiology, DMEPOS). DHSS keys off of the Medicare rate schedule to pay for most of these services. Exceptions occur if Medicare does not have a rate on file. Laboratory tests are paid at 95% of the Medicare rate. Radiology services are paid at 98% of the Medicare rate. DMEPOS items are paid at 98% of the Medicare rate when one has been established.

The opportunity for modernizing the rate schedules, therefore, is low for these services. There may be an opportunity for establishing some value-based component to DMEPOS. Medicare has developed a competitive bid structure for geographic regions across the country. DHSS may consider adopting a competitive bid-like component for some DMEPOS items (e.g., providers willing to accept a rate lower than the published fee-for-service rate).

CATEGORY OF SERVICE	5	ANCILLARY SERVICES
SUB-CATEGORY OF SERVICE	5.1	Physician-Administered Drugs

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$14.1**	Percent of Medicaid Service Budget (including waivers)	0.7%
Federal Share* of Expenditures (in millions)	**$8.1**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$6.0**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	1,113
Total Unique Users, SFY 2019	**21,277**	Total Providers per 1,000 Users, SFY 2019	52.3
Classification: % of Total Population Served	Medium	Classification: Provider Base	Low
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**98.3%**		
Percent of MCO's Service Expenditures	0.9%	Number of Provider Specialties in Category	102
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Actual Acquisition Cost 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 (ASP) plus 6%.

Last rate update for this service	**2017**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	No
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	unknown
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**268**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Low

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Given these are ancillary services, they are not ideal candidates for value-based focused efforts. Instead efforts should be focused on the prescribers and other accountable providers.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS	Avg Paid per Unit MCO
Eculizumab injection	J1300	9.2%	$1,293,413	Priced at invoice or ASP + 6% if under $50.	none	$242.21
Injection, ocrelizumab	J2350	8.3%	$1,173,317		none	$50.78
Injection,onabotulinumtoxina	J0585	6.1%	$854,273		$5.94	$5.53
Etonogestrel implant system	J7307	5.5%	$774,110		$856.78	$736.84
Injection, pegfilgrastim 6mg	J2505	5.0%	$705,586		$4,251.22	$2,960.15

CATEGORY OF SERVICE	5	ANCILLARY SERVICES
SUB-CATEGORY OF SERVICE	5.2	Independent Laboratory and Radiology

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$27.1**	Percent of Medicaid Service Budget (including waivers)	1.3%
Federal Share* of Expenditures (in millions)	**$15.6**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$11.5**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	1,710
Total Unique Users, SFY 2019	**104,873**	Total Providers per 1,000 Users, SFY 2019	16.3
Classification: % of Total Population Served	High	Classification: Provider Base	Low
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**96.1%**		
Percent of MCO's Service Expenditures	1.6%	Number of Provider Specialties in Category	137
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Laboratory services reimbursed at usual and customary charge or a max fee for their service, whichever is lower. The max fee for each procedure will be reviewed annually and adjusted based on the current fees by an inflation factor. Radiology services reimbursed at 95% of Medicare. Independent Radiology services reimbursed at 98% of Medicare with no multiple procedure reduction.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	95-100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**1,320**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Low

Explore Medicare's methodology regarding rates, multiple procedure reductions and/or other caps on services (if applicable after an analysis of claims and services provided).

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Medium

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Using a value-based framework could help reduce uneccesary use of these services in the non-institutional setting to hold both direct service providers and indirect providers accountable for outcomes and cost of care.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Drug test, presumptive, any number of drug classes, devices or procedures	80307	9.8%	$2,668,163	$63.36	$67.31	$40.18
Drug test, definitive, using methods to identify individual drugs	G0480	5.3%	$1,446,677	$78.34	$78.00	$83.46
Tissue exam by pathologist	88305	3.2%	$863,424	$97.57	$58.62	$49.20
Ultrasound without non-stress testing	76819	3.0%	$801,565	$90.61	$78.34	$67.29
Ultrasound real-time with image documentation	76816	2.6%	$706,397	$116.17	$102.72	$89.36

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	5	ANCILLARY SERVICES
SUB-CATEGORY OF SERVICE	5.3	Durable Medical Equipment, Prosthetics and Orthotics

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$22.5**	Percent of Medicaid Service Budget (including waivers)	1.1%
Federal Share* of Expenditures (in millions)	**$13.0**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$9.6**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	419
Total Unique Users, SFY 2019	**21,722**	Total Providers per 1,000 Users, SFY 2019	19.3
Classification: % of Total Population Served	Medium	Classification: Provider Base	Low
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**96.6%**		
Percent of MCO's Service Expenditures	1.4%	Number of Provider Specialties in Category	61
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Reimbursement is 98% of the Medicare fee established unless the DME item is not on the Medicare fee schedule. When not, then rate is the lower of: the provider's usual and customary charges; cost + 20% (includes administration fee); or list price. Prior Authorization is applicable in certain instances.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	Yes
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	Yes
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	95-100%
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**994**	Does the State use this cost data to inform rate?	N/A
Options for modernizing the methodology			Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Medium

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Using a value-based framework could help reduce unneccesary use of these services in the non-institutional setting to hold both direct service providers and indirect providers accountable for outcomes and cost of care.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Durable medical equipment, miscellaneous	E1399	5.7%	$1,276,439	$325.00	$438.60	$5.64
Oxygen concentrator	E1390	4.9%	$1,102,677	$70.39	$69.06	$159.69
Enteral feeding supply kit; pump fed, per day	B4035	3.1%	$695,987	$4.85	$5.82	$10.78
Continuous positive airway pressure (CPAP) device	E0601	2.9%	$660,111	$39.08	$40.94	$84.32
Enteral formula for pediatrics, 100 calories	B4161	2.3%	$518,634	manual	$0.00	$1.84

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

Independent Study of Rate Methodologies for Services Delivered by the Divisions within the Delaware Department of Health and Social Services

Section 6: Mental Health and Substance Use Disorder Services

Section 6 includes two summary reports:

6.1 Substance Use Disorder Services, Outpatient
6.2 Substance Use Disorder Services, Residential Treatment

Note that these are services covered in the regular Medicaid program. Other services related to mental health and substance use disorder that are administered by the DSAMH are discussed in Section VI of this report.

Within this section, the assessment scores show that the priority for rate reform is low. There is greater opportunity to build in a value-based component to rates:

Dashboard Number	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
6.1	Low	Low	Medium	Low	Low	Medium	8
6.2	Low	Low	Low	Low	Medium	Medium	8

Discussion

DHSS is paying close attention to access and payment rates for services in this section. The assessment of low is not because additional reform cannot be done on rate methodologies; rather, it is because this work has recently been completed and remains ongoing. In particular, DHSS received a grant from CMS in 2019 to examine and find better alternatives to how to pay for services related to treating substance use disorder. This activity is ongoing now and is scheduled to be completed in February 2021.

CATEGORY OF SERVICE	6	MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES
SUB-CATEGORY OF SERVICE	6.1	Substance Use Disorder Services, Outpatient Setting

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$31.3**	Percent of Medicaid Service Budget (including waivers)	1.5%
Federal Share* of Expenditures (in millions)	**$18.0**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$13.3**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	204
Total Unique Users, SFY 2019	**10,718**	Total Providers per 1,000 Users, SFY 2019	19.0
Classification: % of Total Population Served	Medium	Classification: Provider Base	Low
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**56.9%**		
Percent of MCO's Service Expenditures	1.1%	Number of Provider Specialties in Category	33
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Government and Private Providers share the same rates. The Medicaid fee schedule is equal to or less than the maximum allowable under the same Medicare rate if the service resides on the Medicare list of covered services, otherwise the state will set local rates and update annually.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	No
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	N/A
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	N/A
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**46**	Does the State use this cost data to inform rate?	N/A
Options for modernizing the methodology			Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments?	No	Level of opportunity to modernize current methodology	Medium

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Develop value-based framework for setting incentive payment dollars aside for use in redistribution based on performance.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Assertive community treatment program, per diem	H0040	33.9%	$10,610,733	All rates are provider-specific	$282.59	$0.00
Methodone administration	H0020	24.0%	$7,509,733		$4.00	$7.18
Intensive outpatient alcohol/drug treatment	H0015	9.9%	$3,108,164		$77.51	$122.00
Residential acute detoxification, alcohol/drug treatment	H0011	5.7%	$1,789,965		$354.67	$506.95
Substance use disorder service, clinic setting	T1015	4.7%	$1,468,760		not paid	$143.55

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	6	MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES
SUB-CATEGORY OF SERVICE	6.2	Substance Use Disorder Services, Residential Treatment

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$20.9**	Percent of Medicaid Service Budget (including waivers)	1.0%
Federal Share* of Expenditures (in millions)	**$12.0**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$8.9**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	36
Total Unique Users, SFY 2019	**1,797**	Total Providers per 1,000 Users, SFY 2019	20.0
Classification: % of Total Population Served	Low	Classification: Provider Base	Low
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**48.1%**		
Percent of MCO's Service Expenditures	0.6%	Number of Provider Specialties in Category	5
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Lessor of: Delaware Medicaid per diem rate plus additional FFS reimbursement using the Delaware Medicaid fee schedule for items covered by not inclusive of per diem; OR the facility's usual and customary charge to privately insured or private-pay beneficiaries; OR if an out of state facility, the lesser if a negotiated per diem reimbursement rate, the facility's usual and customary charge or the Delaware Medicaid per diem rate (if covered but not included in per diem then based on Delaware Medicaid fee schedule.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	No
Do multiple DHSS divisions pay for this?	Yes	Does the State use the Medicare methodology?	N/A
Unit of Payment for Service	Per Diem	What percent of Medicare rate does DHSS pay?	N/A
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**10**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Medium

Medicare recently put forward a new payment methodology for these services that Delaware could consider adopting.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Medium

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Develop value-based framework for setting incentive payment dollars aside for use in redistribution based on performance.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Residential care not otherwise specified, per diem	T2033	51.8%	$10,843,964	All rates are provider-specific	$310.89	$0.00
Alcohol and other drug treatment program, per diem	H2036	21.0%	$4,403,422		$273.25	$223.02
No specific service code provided	blank	20.9%	$4,367,361		not paid	$499.58
Residential acute detoxification, alcohol/drug treatment	H0011	4.3%	$895,500		not paid	$523.38
Alcohol and other drug treatment program, halfway house, per diem	H2034	0.8%	$157,094		not paid	$45.91

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

Section 7: Other Medicaid Services

Section 7 includes four summary reports:

7.1 Children's Dental Services
7.2 Vision and Hearing Services
7.3 Non-Emergency Medical Transportation and Emergency Transportation (Ambulance)
7.4 Private Duty Nursing

Within this section, the assessment scores show that the priority for rate reform or value-based purchasing is greatest for dental services:

Dashboard Number	Percent of Medicaid Budget	Percent of Managed Care Spending	Beneficiary Usage Volume	Provider per 1,000 Beneficiaries	Opportunity to Modernize Payment System	Value-Based Opportunity	Total Score (highest score = 18)
7.1	Low	Low	High	High	Low	Medium	11
7.2	Low	Low	Medium	Medium	Low	Low	8
7.3	Low	Low	Medium	Medium	Low	Low	8
7.4	Low	Low	Low	Low	Medium	Low	7

Discussion

Rates for dental and vision were updated in 2019.

There may be an opportunity for a value-based payment or some other type of incentive payment for dental providers who are willing to accept a certain threshold of Medicaid clients or providers who are willing to accept Medicaid in lower-than-average access areas. State Medicaid Agencies have used different reimbursement strategies to grow their dentist provider pool which is often challenging.

Vision is a very small component of the Medicaid service budget, so this service is not as high a priority.

Non-emergency medical transportation (NEMT) is managed by DMMA directly under a broker contract. The broker coordinates trips for both the managed care and fee-for-service Medicaid populations. This contract can be deemed value-based since the broker is given a pre-paid per member per month amount per Medicaid beneficiary. The NEMT broker is then responsible for coordinating trips for beneficiaries and for paying transportation providers directly.

Rates paid for private duty nursing vary by provider. Rates are reviewed annually. The rate assumes a one nurse-to-one patient ratio, but a discounted rate may be paid if the nurse is serving more than one individual simultaneously. Because cost information to perform the service is not collected, there is an opportunity to provide more clarity related to how rates are set and what is included in the rate payment for each service. There is also an opportunity to develop modifiers to the rate to account for geographic variation, skill set of the nurse, and/or the acuity level of the patient being served.

CATEGORY OF SERVICE	7	OTHER MEDICAID SERVICES
SUB-CATEGORY OF SERVICE	7.1	Children's Dental Services

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$44.9**	Percent of Medicaid Service Budget (including waivers)	2.2%
Federal Share* of Expenditures (in millions)	**$25.8**	Classification: % of Medicaid Service Budget	Medium
State Share of Expenditures (in millions)	**$19.1**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	235
Total Unique Users, SFY 2019	**63,495**	Total Providers per 1,000 Users, SFY 2019	3.7
Classification: % of Total Population Served	High	Classification: Provider Base	High
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**1.1%**		
Percent of MCO's Service Expenditures	0.0%	Number of Provider Specialties in Category	15
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Paid the same as non-clinic dentists per EPSDT Dental Treatment - infants, children and adolescents.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	No
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	N/A
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	N/A
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**217**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Medium

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

Develop value-based framework for adding incentive payment dollars aside for use in redistribution based on performance.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Resin-based composite, two surfaces, posterior	D2392	9.7%	$4,355,012	$199.38	$199.30	$0.00
Dental prophylaxis child (teeth cleaning)	D1120	7.5%	$3,350,533	$59.24	$58.96	$0.00
Periodic oral evaluation	D0120	6.2%	$2,799,694	$44.07	$43.79	$39.71
Dental sealant per tooth	D1351	6.2%	$2,791,361	$47.68	$47.65	$0.00
Topical fluoride varnish	D1206	4.9%	$2,208,633	$36.12	$35.74	$0.00

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	7	OTHER MEDICAID SERVICES
SUB-CATEGORY OF SERVICE	7.2	Vision and Hearing

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$1.6**	Percent of Medicaid Service Budget (including waivers)	0.1%
Federal Share* of Expenditures (in millions)	**$0.9**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$0.7**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	219
Total Unique Users, SFY 2019	**24,555**	Total Providers per 1,000 Users, SFY 2019	8.9
Classification: % of Total Population Served	Medium	Classification: Provider Base	Medium
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**76.8%**		
Percent of MCO's Service Expenditures	0.1%	Number of Provider Specialties in Category	14
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Paid based on a fee schedule.

Last rate update for this service	**2019**	Does Medicare have a rate methodology for this service?	No
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	N/A
Unit of Payment for Service	Per Procedure	What percent of Medicare rate does DHSS pay?	N/A
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**88**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Low

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Low

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit MCO
Vision svcs frames purchases	V2020	22.5%	$367,862	$62.02	$59.81	$48.77
Hearing screening	V5008	22.2%	$364,031	$16.00	$21.00	$7.64
Routine ophthalmological (eye) exam, new patient	S0620	14.1%	$230,980	$120.51	none	$64.57
Routine ophthalmological (eye) exam, established patient	S0621	9.2%	$150,818	$69.20	none	$63.08
Lens, polycarbonate or equal, per lens	V2784	6.1%	$100,610	$45.83	$40.25	$31.78

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	7	OTHER MEDICAID SERVICES
SUB-CATEGORY OF SERVICE	7.3	Emergency (Ambulance) and Non-Emergency Medical Transportation

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$11.7**	Percent of Medicaid Service Budget (including waivers)	0.6%
Federal Share* of Expenditures (in millions)	**$6.7**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$5.0**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	251
Total Unique Users, SFY 2019	**20,858**	Total Providers per 1,000 Users, SFY 2019	12.0
Classification: % of Total Population Served	Medium	Classification: Provider Base	Medium
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**98.2%**		
Percent of MCO's Service Expenditures	0.7%	Number of Provider Specialties in Category	17
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

A transportation broker is reimbursed a monthly capitated rate for each Medicaid client residing in the State to administer Non-Emergency Medical Transportation (NEMT). The broker then negotiates NEMT rates with each transportation provider. For Emergency Transportation, the rates are reimbursed as a percentage of the Medicare Fee Schedule: Ground Mileage, per Statute Mile, 22%; Advanced Life Support, Emergency Transport, 13%; Basic Life Support, Emergency Transport, 17%; Conventional Air Services, Transport One Way, 39%; Rotary Wing Air Mileage, 38%.

Last rate update for this service	**2012**	Does Medicare have a rate methodology for this service?	only
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	only
Unit of Payment for Service	Per Trip	What percent of Medicare rate does DHSS pay?	100%
Is the rate(s) standard or provider-specific?	Specific	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**44**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Low

Incentives could be provided to contractors in areas of the state where transportation is an issue: high-traffic areas (seasonal/beach), rural areas (where distance and coverage are issues), areas where modality coverage issues exists.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments?	No	Level of opportunity to modernize current methodology	Low

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019	Avg Paid per Unit FFS***	Avg Paid per Unit, NEMT Broker
Non-emergency transport, per trip	T2003	52.2%	$6,099,494	$10.10	Paid through NEMT broker	$15.39
Non-emergency transport, wheelchair van, per trip	A0130	15.5%	$1,809,603	$11.01		$41.00
Non-emergency transport, ambulance, basic life support, per trip	A0428	11.3%	$1,322,842	$35.00		$145.86
Non-emergency transportation, per mile	S0215	2.4%	$280,967	$0.42		$1.06
Emergency transport, ambulance, basic life support, per trip	A0429	9.1%	$1,058,438	$65.27	$64.30	$63.79

***The average paid per unit in FFS may differ from the rate on file due to variations such as modifier pricing which may differ from the standard rate.

CATEGORY OF SERVICE	7	OTHER MEDICAID SERVICES
SUB-CATEGORY OF SERVICE	7.4	Private Duty Nursing

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$28.5**	Percent of Medicaid Service Budget (including waivers)	1.4%
Federal Share* of Expenditures (in millions)	**$16.4**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$12.1**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	38
Total Unique Users, SFY 2019	**271**	Total Providers per 1,000 Users, SFY 2019	140.2
Classification: % of Total Population Served	Low	Classification: Provider Base	Low
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
Percent of Service Category Paid by MCOs	**72.4%**		
Percent of MCO's Service Expenditures	1.3%	Number of Provider Specialties in Category	5
Classification: % of MCO Expenditures	Low		

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

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 based on the authorized services. Rates for agency services are reviewed annually, but have not been updated. Agencies will be reimbursed the lower of their usual and customary charges or the maximum rate. Maximum rates are established based on number of individuals: for one individual, 100% of established baseline rate; for two, 50% of 143% of baseline rate; for three, 33% of 214% of baseline rate. The rates paid in managed care for private duty nursing cannot go below the fee-for-service rate established.

Last rate update for this service	**2006**	Does Medicare have a rate methodology for this service?	No
Do multiple DHSS divisions pay for this?	No	Does the State use the Medicare methodology?	N/A
Unit of Payment for Service	Per Hour	What percent of Medicare rate does DHSS pay?	N/A
Is the rate(s) standard or provider-specific?	Standard	Is provider cost information readily available to inform rate?	No
Total Unique # of CPT/HCPCS Codes	**2**	Does the State use this cost data to inform rate?	N/A

Options for modernizing the methodology — Medium

A rate update is merited to capture the latest cost data from providers and the average number of clients that are typically served in one day. A wage survey of private duty nursing was conducted in CY2018. Information could be leveraged from this survey.

INFORMATION RELATED TO VALUE-BASED METHODOLOGY

Does the State use value-based methods as part of these payments? No — Level of opportunity to modernize current methodology: Low

A description of those methods include:

N/A

Options for adding a value-based component (if level of opportunity is rated Medium or High above)

There may be opportunities to build an episodic payment for clients that need private duty nursing on a long-term basis. Also, consumer feedback could be integrated into an incentive-based payment for this service.

AVERAGE PAYMENT PER UNIT FOR THE TOP PROCEDURES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	DHSS Rate in 2019 (1:1 rate)	Avg Paid per Unit FFS***	Avg Paid per Unit MCO***
Nursing care, in the home, LPN, per hour	S9124	84.1%	$24,016,857	$46.14	$40.42	$40.26
Nursing care, in the home, RN, per hour	S9123	15.9%	$4,525,231	$51.50	$43.84	$41.35

***The average paid per unit in FFS or in MCO will differ from the rate on file due to variations such as staffing for multiple clients in the same hour.

SECTION VI: FINDINGS RELATED TO HOME AND COMMUNITY BASED SERVICES AND MEDICAID WAIVER SERVICES ADMINISTERED BY OTHER DIVISIONS

Introduction

The summary reports shown in Section VI are similar to those reported in Section V, but the reports in this section focus on home- and community-based services (HCBS). Some HCBS are administered by the Division of Medicaid and Medical Assistance because they are covered services under the Medicaid entitlement. Other services are limited to those individuals eligible for one of DHSS Medicaid waiver programs approved by the Centers for Medicare and Medicaid. The waiver programs are administered by Divisions other than the DMMA. The common theme to the services shown in Section VI is that they are not medical in nature and they are delivered in a home or community setting.

Continuing the numbering sequence from Section V, the services reported in Section VI have been classified in Section 8, HCBS Services. There are five summary reports that have been organized by the entity that administers the delivery of services. This was done because the rates that are set to pay for the services are developed by each Division separately. The summary reports are:

8.1 HCBS Services Delivered by the MCOs in Medicaid Managed Care (PLUS program)
8.2 HCBS Services Administered by the Division of Developmental Disabilities Services
8.3 HCBS Services Administered by the Division of Substance Abuse and Mental Health (PROMISE program)
8.4 Children's Behavioral Health Services Administered by the Department of Children, Youth and their Families
8.5 School Based Health Services

Program-specific Summaries

Total expenditures the services in this section combined are $334.4 million in State Fiscal Year 2019. The majority of these expenditures, however, appear in summary report 8.1 (PLUS program, $107.0 million) and summary report 8.2 (DDDS, $174.4 million).

Five of the six assessment items used in Section V summary reports are also shown on these reports (the percentage of MCO expenditures was removed). In lieu of scoring each program individually, Burns & Associates' review yielded the same findings related to opportunities. Specific recommendations appear in Section VIII.

- With respect to opportunities to modernize the rate methodology, DHSS may consider a process recently used by the DDDS to conduct its rate update whereby provider cost data was collected. This information, however, should be aligned with market-based cost information to ensure that rates reflect current market conditions.

- With respect to opportunities for value-based components, not every service in every program may have this opportunity, but some are likely candidates for DHSS to build incentives to achieve the outcome desired. This may include, for example, employment targets for the I/DD population (e.g., an incentive payment to providers who are able to assist a beneficiary maintain a job for a defined period) or measuring readmission rates for beneficiaries with behavioral health issues or substance use disorder (e.g., an incentive payment to providers who can reduce re-hospitalizations for these populations).

CATEGORY OF SERVICE	8	HCBS and WAIVER SERVICES
SUB-CATEGORY OF SERVICE	8.1	HCBS Services Administered by the Division of Developmental Disabilities Services

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$174.4**	Percent of Medicaid Service Budget (including waivers)	8.6%
Federal Share* of Expenditures (in millions)	**$100.4**	Classification: % of Medicaid Service Budget	**High**
State Share of Expenditures (in millions)	**$74.0**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	85
Total Unique Users, SFY 2019	**2,862**	Total Providers per 1,000 Users, SFY 2019	29.7
Classification: % of Total Population Served	**Low**	Classification: Provider Base	**Low**

**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers

Number of Provider Specialties in Category: 7

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

The DDDS recently undertook a rate review for all services. Provider cost data was used to inform the rates. In some cases, market-based data such as the actual hourly wage needed to retain Direct Service Professionals, was factored in.

Last rate update for these services	**2019**	Is provider cost information readily available to inform rate?	No
Do multiple DHSS divisions pay for this?	Yes	Does the State use this cost data to inform rate?	Yes
Total Unique # of CPT/HCPCS Codes	88	What percent of Medicare rate does DHSS pay?	N/A

Options for modernizing the methodology: **Medium**

The DDDS has already implemented some strategies to update its rates using provider cost data and market-based costs. Additional work could be done to align rates so that there is more alignment between payment and costs across service categories.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE SERVICES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	Avg Paid per Service
Waiver services, not otherwise specified	T2025	52.8%	$91,990,837	$374.29
Habilitation, residential, waiver, per diem	T2016	22.8%	$39,818,297	$370.22
Day Habilitation, waiver, per diem	T2020	12.1%	$21,086,345	$106.42
Habilitation, pre-vocational, waiver, per diem	T2014	3.4%	$5,957,151	$75.14
Habilitation, supported employment, waiver, per 15 min	T2019	2.0%	$3,516,245	$9.99

CATEGORY OF SERVICE	8	HCBS and WAIVER SERVICES
SUB-CATEGORY OF SERVICE	8.2	HCBS Services Delivered by the MCOs in Medicaid Managed Care (PLUS Program)

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$107.0**	Percent of Medicaid Service Budget (including waivers)	5.3%
Federal Share* of Expenditures (in millions)	**$61.6**	Classification: % of Medicaid Service Budget	**Medium**
State Share of Expenditures (in millions)	**$45.4**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	225
Total Unique Users, SFY 2019	**5,300**	Total Providers per 1,000 Users, SFY 2019	42.5
Classification: % of Total Population Served	**Low**	Classification: Provider Base	**Low**

**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers

Number of Provider Specialties in Category	34

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

The managed care organizations under contract with the DMMA set their own rates to pay for the services that are covered for individuals enrolled with their MCO that are eligible for the DSHP Plus LTSS program. These are indviduals who meet nursing facility level of care and individuals who meet hospital level of care and have HIV/AIDS.

Last rate update for these services	**N/A**	Is provider cost information readily available to inform rate?	No
Do multiple DHSS divisions pay for this?	No	Does the State use this cost data to inform rate?	No
Total Unique # of CPT/HCPCS Codes	26	What percent of Medicare rate does DHSS pay?	N/A

Options for modernizing the methodology **High**

One method to update rates is to define the key cost components related to each service definition. Collect cost data from the providers. Compare the provider's cost data to market-based data such as the current competitive wage and fringe benefit package for workers. Compare the actual provider costs to market-based costs to determine misalignment. Build a rate from the ground up using a combination of these inputs. Align rates for a service so that they are comparable across providers.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE SERVICES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	Avg Paid per Service
Homemaker service not otherwise specified, per 15 min	S5130	57.2%	$61,172,005	$4.81
Personal care service, per 15 min	T1019	22.0%	$23,577,930	$3.32
Home-delivered prepared meal	S5170	5.3%	$5,685,116	$7.58
Attendant care service, per 15 min	S5125	4.8%	$5,151,420	$5.19
Day care service, center-based, per diem	S5105	3.1%	$3,305,361	$83.65

CATEGORY OF SERVICE	8	HCBS and WAIVER SERVICES
SUB-CATEGORY OF SERVICE	8.3	HCBS Services Administered by the Division of Substance Abuse and Mental Health (PROMISE Program) other than SUD Treatment

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$2.4**	Percent of Medicaid Service Budget (including waivers)	0.1%
Federal Share* of Expenditures (in millions)	**$1.4**	Classification: % of Medicaid Service Budget	Low
State Share of Expenditures (in millions)	**$1.0**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	3
Total Unique Users, SFY 2019	**1,494**	Total Providers per 1,000 Users, SFY 2019	2.0
Classification: % of Total Population Served	Low	Classification: Provider Base	High
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
		Number of Provider Specialties in Category	1

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Current rate methodology is unknown.

Last rate update for these services	**TBD**	Is provider cost information readily available to inform rate?	No
Do multiple DHSS divisions pay for this?	Yes	Does the State use this cost data to inform rate?	No
Total Unique # of CPT/HCPCS Codes	2	What percent of Medicare rate does DHSS pay?	N/A

Options for modernizing the methodology — High

One method to update rates is to define the key cost components related to each service definition. Collect cost data from the providers. Compare the provider's cost data to market-based data such as the current competitive wage and fringe benefit package for workers. Compare the actual provider costs to market-based costs to determine misalignment. Build a rate from the ground up using a combination of these inputs. Align rates for a service so that they are comparable across providers.

AVERAGE PAYMENT PER UNIT FOR THE TOP SERVICES (in DHSS Data Warehouse, excludes DSAMH internal warehouse)

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	Avg Paid per Service
Case management, per month	T2022	90.6%	$2,208,217	$248.51
Personal care service, per 15 min	T1019	9.4%	$228,062	$5.85

CATEGORY OF SERVICE	8	HCBS and WAIVER SERVICES
SUB-CATEGORY OF SERVICE	8.4	Children's Behavioral Health Services Administered by the Department of Children, Youth and their Families

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$41.3**	Percent of Medicaid Service Budget (including waivers)	2.0%
Federal Share* of Expenditures (in millions)	**$23.8**	Classification: % of Medicaid Service Budget	**Medium**
State Share of Expenditures (in millions)	**$17.5**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	7
Total Unique Users, SFY 2019	**2,574**	Total Providers per 1,000 Users, SFY 2019	2.7
Classification: % of Total Population Served	**Low**	Classification: Provider Base	**High**
		**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers	
		Number of Provider Specialties in Category	2

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Current rate methodology is unknown.

Last rate update for these services	**TBD**	Is provider cost information readily available to inform rate?	No
Do multiple DHSS divisions pay for this?	Yes	Does the State use this cost data to inform rate?	No
Total Unique # of CPT/HCPCS Codes	20	What percent of Medicare rate does DHSS pay?	N/A

Options for modernizing the methodology **High**

One method to update rates is to define the key cost components related to each service definition. Collect cost data from the providers. Compare the provider's cost data to market-based data such as the current competitive wage and fringe benefit package for workers. Compare the actual provider costs to market-based costs to determine misalignment. Build a rate from the ground up using a combination of these inputs. Align rates for a service so that they are comparable across providers.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE SERVICES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	Avg Paid per Service
No specific service identified	blank	55.1%	$22,772,295	$591.93
Community psychiatric supportive treatment, face-to-face, per 15 min	H0036	29.4%	$12,159,093	$34.33
Behavioral health, short-term residential, per diem	H0018	8.0%	$3,314,495	$449.85
Crisis intervention service, per 15 min	H2011	6.2%	$2,581,220	$89.52
Multisystemic therapy for juveniles, per 15 min	H2033	0.5%	$206,243	$61.49

CATEGORY OF SERVICE	8	HCBS and WAIVER SERVICES
SUB-CATEGORY OF SERVICE	8.5	School Based Health Services

GENERAL INFORMATION

Expenditure Information on State Fiscal Year 2019 Incurred Services:

Service Expenditures, SFY 2019 (in millions)	**$9.3**	Percent of Medicaid Service Budget (including waivers)	0.5%
Federal Share* of Expenditures (in millions)	**$5.3**	Classification: % of Medicaid Service Budget	**Low**
State Share of Expenditures (in millions)	**$3.9**		

*Note that the Federal Share shown is the minimum estimated amount. Different services may have different federal matching rates. Therefore, the value shown is the amount if all services were matched at the lowest rate from CMS.

Population Information:

Total Unique Number of Enrolled, SFY2019	**295,743**	**Total Providers** Delivering Service, SFY 2019**	35
Total Unique Users, SFY 2019	**35,206**	Total Providers per 1,000 Users, SFY 2019	1.0
Classification: % of Total Population Served	**High**	Classification: Provider Base	**High**

**The count of providers is derived from billing identification numbers such that unique specialty and/or locations are counted as separate providers

Number of Provider Specialties in Category: 1

INFORMATION RELATED TO RATE SETTING METHODOLOGY

Overview of Current Rate Methodology

Current rate methodology is unknown.

Last rate update for these services	**TBD**	Is provider cost information readily available to inform rate?	No
Do multiple DHSS divisions pay for this?	No	Does the State use this cost data to inform rate?	No
Total Unique # of CPT/HCPCS Codes	22	What percent of Medicare rate does DHSS pay?	N/A

Options for modernizing the methodology — **Medium**

One method to update rates is to define the key cost components related to each service definition. Collect cost data from the providers. Compare the provider's cost data to market-based data such as the current competitive wage and fringe benefit package for workers. Compare the actual provider costs to market-based costs to determine misalignment. Build a rate from the ground up using a combination of these inputs. Align rates for a service so that they are comparable across providers.

AVERAGE PAYMENT PER UNIT FOR THE TOP FIVE SERVICES

Service Short Descriptor	Service Code	Pct Spend in this Category	$$ Expenditures	Avg Paid per Service
Therapeutic behavioral services, per diem	H2020	28.8%	$2,678,281	$271.60
Speech/hearing therapy	92508	13.3%	$1,236,225	$21.19
Non-emergency transportation, per diem	T2002	11.5%	$1,067,639	$42.51
Physician-coordinated care oversight services	G9008	10.4%	$964,957	$365.93
Therapeutic activities	97530	9.8%	$909,696	$17.29

Services that Cross Multiple DHSS Divisions

By nature of the types of services delivered, there are some instances multiple Divisions are administering programs that have the same (or almost the same) service. This is especially true for HCBS services. It has been the experience of B&A working with other states that often a state's Divisions are competing with each other for the same provider base because the rates that they are paying for the same service will vary. The Division with the highest rate will attract the most providers.

B&A evaluated the extent to which payment rates for a given service may vary across programs within Delaware's Divisions/programs. We also assessed the degree of overlap in the specific providers that are delivering services across programs. In particular, B&A reviewed services and rates in the following programs:

- The Diamond State Health Plan – Plus program operated by the Division of Services for Aging and Adults with Physical Disabilities
- The Lifespan Waiver and the Pathways to Employment Waiver operated by the Division of Developmental Disabilities Services
- The Promoting Optimal Mental Health Through Supports and Empowerment (PROMISE) program operated by the Division of Substance Abuse and Mental Health
- The AIDS Waiver operated by the Division of Medicaid and Medical Assistance
- Rehab Services covered by the Division of Medicaid and Medical Assistance

These programs cover a variety of services, some of which are unique to a single program. For the purposes of this evaluation, B&A only considered services that are similar across multiple programs, including:

- Attendant Care
- Personal Care
- Day Habilitation / Adult Day Health
- Prevocational Training
- Individual Supported Employment
- Group Supported Employment

Exhibit 6 on the next page compares the utilization, total expenditures and the average effective rate for each of these services in the various HCBS programs. Although there is some variability in rates across the programs, the variation is usually within ten percent. The exception to this is service #5, Day Habilitation or Adult Day Health. The rate paid by DDDS is 14% higher than the rate in the PLUS program and 17% higher than what is paid in the Rehab Services portion of DMMA's services.

Exhibit 6

Units Billed, Average Rate Paid and Spending by Each Program for Services that Cross Multiple Programs

			HCBS Services in Medicaid Managed Care (PLUS Program)	Services in the DDDS Waiver	I/DD Pathways to Employment Program (not in waiver)	PROMISE Program at DSAMH	Services in the AIDS Waiver	Rehab Services Outside of Waivers
1	Attendant Care	Unit	976,479				20,892	
		Rate	$5.15				$4.76	
		Spending	$5,029,959				$99,508	
2	Personal Care from Home Health Agencies	Unit	6,547,052			0	30,920	
		Rate	$6.29				$6.43	
		Spending	$41,151,230			$0	$198,664	
3	Personal Care - Other	Unit	13,122,318				85,118	
		Rate	$3.31				$3.32	
		Spending	$43,489,922				$282,594	
4	Day Habilitation or Adult Day Health (billed per 15 min)	Unit	0	102,234				197,844
		Rate		$7.49				$7.54
		Spending	$0	$765,620				$1,492,375
5	Day Habilitation or Adult Day Health (billed per day)	Unit	46,956	116,541				81,607
		Rate	$99.27	$113.02				$96.99
		Spending	$4,661,274	$13,171,124				$7,915,221
6	Prevocational Training (billed per 15 min)	Unit		78,503				34,378
		Rate		$7.48				$8.23
		Spending		$587,449				$282,941
7	Prevocational Training (billed per day)	Unit		45,304				33,980
		Rate		$77.91				$71.44
		Spending		$3,529,749				$2,427,403
8	Supported Employment-Individual	Unit		131,505	63,584			150,114
		Rate		$13.49	$13.55			$13.49
		Spending		$1,774,521	$861,567			$2,025,647
9	Supported Employment-Group	Unit		135,395	5,388			63,412
		Rate		$4.76	$3.97			$4.21
		Spending		$644,134	$21,373			$266,905

B&A also examined the individual providers that were paid for the services shown in Exhibit 6 to see how much overlap there was across programs. There was less overlap than expected. Where overlap did exist, the payments made to providers was usually low compared to total program expenditures. The exceptions to this were as follows:

- There are 10 providers that are paid under the DDDS waiver and the DMMA Rehab Services option for Day Habilitation or Adult Day Health when billed per 15 minutes.
    - For DDDS, these 10 providers are out of a total of 11 providers (91%).
    - For Rehab Services, these 10 providers are out of a total of 15 providers (67%).

- Similarly, there are 17 providers that are paid under the DDDS waiver and the DMMA Rehab Services for Day Habilitation or Adult Day Health when billed per day.
    - For DDDS, this is 17 out of 19 providers (89%).
    - The same is true for Rehab Services, 17 out of 19 providers (89%).
    - There are also five providers (out of 15) billing for this service in the PLUS program

- There was also overlap between DDDS and the DMMA Rehab Services for the limited number of providers that bill for Prevocational Training per 15 minutes.
    - All four providers that bill DDDS also bill DMMA.
    - Four out of the five providers that bill DMMA also bill DDDS.

- The overlap also occurred for Prevocational Training when billed per day.
    - All five providers that bill DDDS also bill DMMA.
    - Five out of the six providers that bill DMMA also bill DDDS.

- Overlap was also found for the Supported Employment, Individual service between DDDS and the DMMA Rehab Services. There were 14 providers that billed both programs.
    - For Supported Employment, Group service, there were four providers in common across the two programs.

SECTION VII: FINDINGS RELATED TO SERVICES PAID FOR NON-MEDICAID SERVICES BY OTHER DIVISIONS

Introduction

The services that were reviewed in Sections V and VI represented those services that are billed to DHSS on a per service basis and stored in the Delaware Medicaid Enterprise System (DMES). This includes services covered in the Medicaid program. For other Divisions in DHSS, services are not paid for in this manner. The method in which services are paid is using a vendor contract.

When vendor contracts are initiated, there may or may not be a pre-determined rate that has been established by the Division to pay for the service. In most situations, the Division has requested proposals from vendors to deliver a service or set of services. The Division may establish the rate it desires to pay for the service as part of the Request for Proposal (process). In other cases, the Division may ask vendors to propose their best rate to deliver the service.

For this report, Burns & Associates (B&A) released a survey to the Divisions within DHSS other than the Division of Medicaid and Medical Assistance (DMMA) to obtain information about contracts that the Division has with providers for services rendered to Delawareans. Among the 10 Divisions other than DMMA, five Divisions provided information in the survey request. For these five Divisions, a one-page summary report appears in this section to delineate each Division's contracts and method to set rates in these contracts.

For three other Divisions (Child Support Services, Health Care Quality and Management Services), the survey was not applicable since the Divisions do not have direct client-facing activities. Another Division (Visually Impaired) had very small contracts collectively totaling $29,000. The Division of Social Services did not provide information per se, but B&A utilized publicly-available information about the Purchase of Care (POC) program which provides child care assistance. This program is discussed below.

Purchase of Care

The Division of Social Services administers Delaware's child care assistance program. This program makes payments to child care providers on behalf of lower-income families with children under the age of 13 years to enable the caretaker to hold a job, obtain training, or meet the special needs of the child. The program relies on a combination of State General Funds and federal dollars granted through the Child Care and Development Fund (CCDF) and Temporary Assistance for Needy Families (TANF).

Provider rates vary based on the county of the provider, the age of the child (under one year, one year, two-to-five years, and six years and older), the type of provider (centers and licensed home/ large family/ relative providers), and whether or not the child has special needs. The rates are fixed and do not vary by provider; for example, all child care centers in New Castle are paid the same rate for serving a one year-old without special needs. In addition to the POC payments, the Delaware Department of Education (DOE) provides supplemental payments (referred to as "tiered reimbursement") to providers that participate in Delaware Stars, a quality rating and improvement system, and have achieved Star Level 3, Star Level 4, or Star Level 5. The payments are tiered with payments increasing as a provider's Star Level increases. The payments are significant, representing a 23 percent increase to the POC rates for Star Level 3 providers, a 43 percent increase for Star Level 4 providers, and a 57 percent increase for Star Level 5 providers.

Given that state child care programs account for a relatively small share of the child care market, state programs typically benchmark their rates to the market rates charged to families who directly pay for child care. Additionally, state programs using federal CCDF dollars must comply with federal

regulations related to payment rates. These regulations do not dictate actual payment rates, but do require that rates be "sufficient to ensure equal access, for eligible families … to child care services comparable to those provided to families not eligible to receive CCDF assistance…"[12] Regulations further require that payment rates be based on a market rate survey conducted within two years of the submittal of a state's CCDF Plan (CCDF Plans must be submitted every three years so, effectively, a market rate survey must be conducted at least every three years). Federal guidance has suggested that payments established at the 75th percentile of the market rate survey – the rates at which the payment is equal to or greater than the rates charged by 75 percent of providers – would be regarded as providing equal access.[13] Though suggested, states are not required to adopt this benchmark.

In fact, in a 2019 report, the U.S. Department of Health and Human Services' (DHHS) Inspector General found that only six states have set rates at or above the 75th percentile for center-based care and only seven states pay at or above the 75th percentile for home-based care.[14] Commenting on child care payment rates across the country, DHHS has expressed concern that "inadequate rates may violate the statutory requirements for equal access and [that] CCDF is serving a large number of vulnerable children who would benefit from access to high-quality care and for whom payment rates even higher than the 75th percentile may be necessary to afford access to such care."[15]

Like nearly every state, Delaware's child care program has not adopted the 75th percentile benchmark. As stated in the most recent study of child care rates published by the Division that was conducted in 2018[16], prior to rate increases granted in 2019, DSS set rates at the 50th percentile of the most recent market rate survey. This means that the rates were equal to or greater than the market rates charged by half of the State's child care providers.[17] Effective July 1, 2019, POC payment rates were increased to 65 percent of the 75th percentile rates established by the market rate survey. Since POC rates had not been increased since 2011, the 2019 rate increases were substantial, ranging from nine to 30 percent in New Castle County.

DOE's supplemental tiered reimbursement rates were also increased in 2019. Considering the combined POC rates and supplemental tiered rates, total payments for Star Level 5 providers exceed the 75th percentile benchmark, but the combined rates for Star Levels 3 and 4 providers – as well as Star Levels 1 and 2 providers that are not eligible for tiered reimbursement – generally remain below this benchmark.

Division-specific Summaries

Collectively, the five Divisions that reported contracts with providers that deliver services to clients had a total contract value of $126.2 million total funds and $79.5 million state share. This compares to $2.26 billion in total funds reported for the service categories in Sections V and VI.[18] A total of 453 different contracts were reported (the same provider can have more than one contract with a Division).

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[12] 45 CFR 98.45
[13] 63 Fed. Reg. 39959 (July 24, 1998)
[14] U.S. Department of Health and Human Services. *States' Payment Rates Under the Child Care and Development Fund Program Could Limit Access to Child Care Providers (OEI-03-15-00170).* Washington, D.C. August 2019. Accessed at https://www.oig.hhs.gov/oei/reports/oei-03-15-00170.pdf.
[15] 81 Fed. Reg. 67512 (September 30, 2016)
[16] Horrace, William and Christopher Parmeter. *2018 Delaware Local Child Care Market Rate Survey.* Accessed at https://dhss.delaware.gov/dhss/files/mrs2018chcarerpt.pdf.
[17] Delaware Department of Health and Social Services. *Child Care and Development Fund (CCDF) Plan for Delaware, FFY 2019-2021.* Accessed at https://www.dhss.delaware.gov/dhss/dss/CCDF_State_Plan_2019-2021.pdf.
[18] Total payments in the DMES for State Fiscal Year 2019 services were closer to $2.72 billion, but some data was excluded from the study such as payments for services where Medicare, not Medicaid, was the primary payer.

As shown in the reports on the following pages, the majority of provider contracts reported by each Division were through the competitive bid process. There was variation among the Divisions whether or not the Division set the rate paid to the provider when the Request for Proposals (RFP) was released or whether the Division requested a best offer from the provider.

Discussion

From the survey data received and face-to-face interviews with the Division staff responsible for these contracts, there appears to be some opportunities for ensuring the best value to the State. Many staff members reported that retaining and attracting providers can be challenging. As a result, the rate proposed by the provider is often accepted, even if this rate differs from its peers. There may be situations where the variation in the rates are merited, such as geographic or credentials/experience of the provider. Prior to accepting a provider's proposed rate, the Divisions could conduct research to "build up" the cost components of a rate to determine an acceptable range within a provider's proposed rate may be accepted. Further, any opportunities where a value-based component such as performance targets should be explored that may influence the final rate negotiated with the provider.

DPH: The Division of Public Health

The Division of Public Health protects and promotes the health of all people in Delaware. The current priorities focus on improving health-related lifestyles; improving access to integrated, prevention-focused quality and safe health care as part of health system reform; achieving health equity; preventing opiate abuse and misuse; and improving performance through performance management and improving organizational culture.

CONTRACT INFORMATION

Total Division Expenditures, SFY 2019	**$ 28,861,629**
Federal Share of Expenditures	**$ 9,439,685**
State Share of Expenditures	**$ 19,421,945**
Total Number of Provider Contracts	94

Contract Types
Among the highest dollar contracts shown below, 10 were developed through a competitive bid process where the provider bid a price. Other contracts have rates set by legislation or use the Medicaid fee-for-service rates.

Top Contracts (by total dollars):

Type of Services	Contract Amount	% of Contract Dollars	Clients Served	Number of Vendors	Most Recent Update
Ryan White	$ 10,725,363	37.2%	1,621	12	Not available
School Based Health Services	$ 4,543,246	15.7%	11,430	7	2017
Home Visiting	$ 3,721,506	12.9%	5	5	Not available
Healthy Women Health Babies	$ 2,300,000	8.0%	7	7	Not available
Child Development Watch Programs	$ 1,627,533	4.3%	100s	1	Not available
HIV/AIDS Prevention Services	$ 1,165,348	4.0%	10,019	5	1/1/2019
Title X Services	$ 1,030,754	3.6%	20,000	9	2/1/2020
Early Childhood Educator	$ 715,557	2.5%	2,024	2	7/1/2015
Patient Navigators	$ 706,729	2.4%	4,500	8	12/31/2018
Nursing Services to Non-Public Schools	$ 539,500	1.9%	9,244	11	2017
Lab Services for DPH and DSAAPD	$ 400,000	1.4%	1000s	1	Not available
WIC	$ 303,505	1.1%	10,000	4	11/1/2008
Speech Language Pathology	$ 229,838	0.8%	2,024	2	7/1/2015
WIC	$ 185,605	0.6%	15,000	1	Not available
Nursing	$ 109,275	0.4%	85	1	7/1/2015
Licensed Clinical Social Work	$ 102,660	0.4%	2,024	1	7/1/2015

DSAMH: The Division of Substance Abuse & Mental Health

The Division of Substance Abuse and Mental Health's core services provide prevention and treatment services to Delawareans with mental health, substance use, problem gambling, and co-occurring conditions. DSAMH works to ensure that behavioral health and substance use disorder services are accessible and effective, facilitate recovery and are integrated into the community.

CONTRACT INFORMATION

Total Division Expenditures, SFY 2019	**$ 50,157,817**
Federal Share of Expenditures	**$ 9,402,907**
State Share of Expenditures	**$ 40,754,910**
Total Number of Provider Contracts	183

Contract Types

A significant volume of services paid by DSAMH are paid using rates set on a fee schedule. Claims are billed to the State.

The information below represents expenditures paid through contracts. Among the highest dollar contracts shown below, all were developed through a competitive bid process. Of these, DSAMH set the rate on seven contracts. The provider

Top Contracts (by total dollars):

Type of Services	Contract Amount	% of Contract Dollars	Clients Served	Number of Vendors	Most Recent Update
Crisis Intervention Mobile	$ 11,203,447	22.3%	2,677	43	Not available
Benefits Counseling	$ 8,920,897	17.8%	1,377	31	Not available
Psychosocial Rehabilitation	$ 7,148,457	14.3%	394	15	Not available
Crisis Intervention Not Mobile	$ 5,974,713	11.9%	1,864	21	Not available
SUD Residential Treatment	$ 5,387,666	10.7%	1,029	17	Not available
Community Transition Services	$ 4,353,823	8.7%	7,271	21	Not available
Peer Support	$ 2,676,038	5.3%	Not available	11	Not available
Instrumental Activities For Daily Living	$ 2,486,859	5.0%	2,429	4	Not available
Community Psychiatric Support & Treatment	$ 890,575	1.8%	446	4	Not available
Prevention - Adult and Youth	$ 823,883	1.6%	Not available	10	Not available
Personal Care	$ 230,314	0.5%	Not available	5	Not available

DDDS: The Division of Developmental Disabilities Services

The Division of Developmental Disabilities Services provides supports and services to individuals with intellectual and developmental disabilities, including brain injury, autism (including Asperger's disorder) and other related developmental disabilities and their families. DDDS' system is based on the principles of self-determination, person-centered thinking, self-advocacy and choice.

CONTRACT INFORMATION

Total Division Expenditures, SFY 2019	**$ 939,056**
Federal Share of Expenditures	**$ -**
State Share of Expenditures	**$ 939,056**
Total Number of Provider Contracts	30

Contract Types

The vast majority of services paid by DDDS are paid using rates set on a fee schedule (Refer back to Dashboard 8.1). Claims are billed to the State.

The information below represents the small component of expenditures paid through contracts. Among this smaller amount, most contracts are competitively awarded whereby the DDDS set the rate in advance.

Top Contracts (by total dollars):

Type of Services	Contract Amount	% of Contract Dollars	Clients Served	Number of Vendors	Most Recent Update
Dental Services	$ 569,472	60.6%	500	10	12/31/2019
Mental Health Services	$ 200,321	21.3%	500	7	12/31/2019
Stockly Center Residents Services	$ 51,595	5.5%	46	1	12/31/2018
Educational Services for Sexuality/ Relationships	$ 49,000	5.2%	200	1	12/31/2019
Nutrition Services	$ 29,895	3.2%	200	1	12/31/2019
Sign Language Interpretation	$ 23,976	2.6%	100	1	12/31/2019
Optometry Services	$ 4,848	0.5%	400	3	12/31/2019

DSAAPD: The Division of Services for Aging & Adults with Physical Disabilities

The Division of Services for Aging and Adults with Physical Disabilities maintains and improves the quality of life of people with disabilities and older adults in Delaware by providing home and community-based services and long-term care. DSAAPD promotes healthy communities by administering a variety of person-centered services that promote dignity, well-being and inclusion.

CONTRACT INFORMATION

Total Division Expenditures, SFY 2019	**$ 17,365,492**
Federal Share of Expenditures	**$ 9,512,365**
State Share of Expenditures	**$ 7,853,127**
Total Number of Provider Contracts	30

Contract Types

Among the highest dollar contracts shown below, all but one were developed through a competitive bid process where the provider proposed a rate to DSAAPD. One of the smaller-dollar contracts was initiated through a sole source contract.

Top Contracts (by total dollars):

Type of Services	Contract Amount	% of Contract Dollars	Clients Served	Number of Vendors	Most Recent Update
Home Delivered Nutrition	$ 4,862,663	28.0%	4,199	4	2019
Personal Care	$ 3,904,158	22.5%	808	14	2019
Congregate Nutrition	$ 1,792,654	10.3%	9,696	3	2019
Senior Community Service Employment Program	$ 1,589,932	9.2%	248	3	2019
Adult Day Service	$ 1,522,162	8.8%	234	7	2019
Personal Attendant Services	$ 1,286,455	7.4%	113	2	2019
Respite Care	$ 799,982	4.6%	159	6	2019
Lifespan Respite	$ 341,570	2.0%	181	1	2019
Community Living	$ 214,268	1.2%	63	1	2019
Caregiver Resource Center	$ 210,974	1.2%	600	5	2019
Legal Services	$ 191,166	1.1%	254	1	2019
Personal Emergency Response System	$ 159,606	0.9%	1,105	3	2019
Alzheimer's Day Service	$ 117,122	0.7%	47	0	2019

DSSC: The Division of State Service Centers

The Division of State Service Centers provides direct client services to vulnerable populations, administers state and federal funds to assist low-income persons and families, and coordinates volunteer and service activities.

CONTRACT INFORMATION

Total Division Expenditures, SFY 2019	**$ 29,100,184**
Federal Share of Expenditures	**$ 18,345,946**
State Share of Expenditures	**$ 10,754,238**
Total Number of Provider Contracts	116

Contract Types

Among the 13 highest dollar contracts shown below, DSSC reported that nine were procured through competitive bids. Of these, in five cases the DSSC set the price. For the other four, the bidder offered a price. One contract was not competitive, but DSSC set the rate. Information on the other contracts was not reported.

Top Contracts (by total dollars):

Type of Services	Contract Amount	% of Contract Dollars	Clients Served	Number of Vendors	Most Recent Update
Emergency Assistance Services	$ 3,768,948	13.0%	Not available	0	Not available
Emergency Shelter / Transitional Housing	$ 1,658,600	5.7%	3,423	13	Not available
School Readiness	$ 1,257,546	4.3%	166	48	4/1/2019
Replacing, Repairing Heaters & Conserving Energy	$ 623,773	2.1%	Not available	1	Not available
Access and Visitation Program	$ 573,000	2.0%	639	2	4/1/2019
Utility Assistance Program	$ 569,925	2.0%	Not available	0	Not available
Improving Educational Outcomes	$ 480,368	1.7%	2,887	6	9/1/2019
Community Food Program	$ 433,700	1.5%	Not available	0	Not available
Food Closet / Community Food, Nutrition	$ 433,700	1.5%	100,000	2	Not available
Veterans & Military Families	$ 421,157	1.4%	30	2	9/1/2019
Safe Havens	$ 400,000	1.4%	21	1	4//1/2019
Environmental Stewardship	$ 299,568	1.0%	150,000	1	9/1/2019
Economic Opportunity	$ 299,567	1.0%	250	1	9/1/2019

SECTION VIII: RECOMMENDATIONS TO IMPROVE DHSS RATE SETTING PROCESSES

Introduction

Based on our review of claims and managed care encounter data from the State's data warehouse, the in-person interviews with staff involved in rate setting within each DHSS Division, and our experience setting and reviewing rates for a variety of medical and social services for other state agencies, Burns & Associates (B&A) offers recommendations to improve the rate setting process across DHSS. These recommendations relate to medical services administered by the DMMA, to HCBS services administered by multiple DHSS Divisions, and to contracts administered by most DHSS Divisions.

B&A's recommendations are intended first and foremost to suggest ways to build the framework so that rates can be reviewed efficiently on a regular basis. More specifically, we offer recommendations on how to easily pinpoint wide variations from either industry standards or third-party benchmark data such as the prevailing wage for job categories that are employed by various provider agencies. Therefore, our recommendations are centered around ways to adapt Delaware's DHSS to common industry standards as well as ways to strengthen rate methodologies that are specific to Medicaid-covered services.

Recommendations

1. ***DHSS is encouraged to build rate methodologies that are specific to each service that is purchased and not to build a uniform "one size fits all" methodology. That being said, some service categories can have rate methodologies that are common in the way that they are built. The difference lies in accounting for variations based on the definition of the service being purchased***.

   B&A's experience has found that there is never a single "rate schedule" covering all services that are paid by health purchasers. This is true in the commercial market as well as the public sector markets (Medicare, Medicaid, Department of Defense and Veteran's Affairs). This was exemplified in Exhibit 1 on page II-4 that itemized the 17 different rate schedules developed for the Medicare program. Further, some rate schedules have become more common as "industry practice" while others are specific to each payer's programs.

   For acute health care services in particular, B&A has often observed in our work with State Medicaid Agencies that is industry practice to adopt the methodologies are those used by CMS in whole or in part. Private commercial insurance payers have also adopted some of the CMS methodologies. Within DHSS, the DMMA (the Medicaid Division) has adopted most of the CMS Medicare methodologies already. Although B&A has offered a prioritization to focus resources on areas of opportunity within the DMMA service array, B&A does not believe that this needs to be the highest priority. Specific recommendations for DMMA services appear later in this list of recommendations.

   Instead, B&A suggests that priority be centered on rate schedules for which there is no CMS benchmark. These tend to be services that are payer-specific in nature such as home- and community-based services (HCBS) in Medicaid waiver programs. Whereas it is tempting to compare the rate methodologies and the rates themselves for HCBS across State Medicaid Agencies as a way to benchmark, B&A finds that a service may have the same name across states but very different definitions of the service across states. Examples of differences include the amount of time to deliver the service (e.g., 15 minutes, one hour), the location of the service delivery (e.g., in the home or in a congregate setting), and the qualifications of the personnel delivering the service (e.g., high school diploma or licensed practitioner). Consequently, these rate schedules have not evolved to the point of a generally accepted industry standard. B&A offers a specific recommendation below on how to build consistency in the rate methodology for these services while also adapting to the specifics of each service definition.

2. ***DHSS is encouraged to develop a long-term roadmap for assigning the periodicity of updates of rates for all of its services.***

   More specifically, any guiding roadmap should also include the following:
   - Track if Medicare has a methodology in place that could be considered in whole or in part by DHSS;
   - Track whether DHSS will incorporate a value-based component to its rate methodology or quality reporting on the services being paid;
   - Identify the resources (both internal and external) to make changes to the methodologies and later to update rates periodically;
   - Assess where there are gaps in current resources to complete this work;
   - Identify the modes of communication to external stakeholders required when changes occur (e.g., in-person meetings with providers, briefings to legislators, written provider bulletins, and updated provider billing manuals);
   - Prepare, in advance, the timing and cadence of updates to align with annual legislative budget preparations;
   - Prepare, in advance, the timing needed to introduce value-based initiatives into each rate methodology where it is warranted and any associated quality-based reporting needed to ensure that the value-based initiative has a positive return on investment. B&A often sees states first introduce a new rate methodology without a value-based initiative included to get the new approach on solid footing, then a value-based component is added later.

   B&A believes that the development of a roadmap such as the one described above could be prepared within six months to cover all significant service categories delivered by DHSS Divisions. The implementation of activities in the roadmap, however, will require additional resources. None of the Divisions that deliver Medicaid covered services (DMMA, DSAMH, DDDS, or DSAAPD) have sufficient staffing to undertake significant rate changes immediately. It is often true that State Medicaid Agencies will hire subject matter experts to expedite the initial implementation of a new rate methodology and then will take over ongoing maintenance of the rates after the new methodology has been implemented.

3. ***B&A recommends that DHSS consider augmenting the existing staff currently used to develop and maintain rate methodologies and to clearly define roles and responsibilities for the staff that perform this function***.

   Although DHSS can gain efficiencies by piggy-backing off of well-established methodologies such as those developed by CMS, there remains a need for ongoing maintenance simply because the nature of the delivery of health care is changing (e.g., inpatient hospital setting vs. outpatient hospital setting vs. in a doctor's office) and the costs associated with medical and community-based services changes at different paces (e.g., the cost to conduct lab tests is predictable year-to-year, but the costs to deliver an in-home waiver service can vary quite a bit year to year depending upon the hourly wage of the staff person, their fringe benefit costs like health insurance, and gasoline costs to travel to each client's home).

   B&A offers the following recommendation for maintaining the following full-time staff to support rate development and rate changes:

   - Within the Division of Medicaid and Medical Assistance (DMMA)
     - 1 FTE to serve as manager and to assist in the development of value-based initiatives
     - 1 FTE to focus on hospital reimbursement (inpatient and outpatient services)
     - 1 FTE to focus on nursing facility and other nursing-related services (e.g. home health, private duty nursing)

  - 1 FTE to focus on other professional services where DMMA keys off of Medicare's reimbursement methodologies (e.g. physicians, medical equipment, hospice, dialysis)
  - 1 FTE to focus on Medicaid-only services (e.g. transportation, substance use disorder)

  In addition to maintaining the fee schedules within fee-for-service, these FTEs would also serve as the liaison to the managed care organizations to oversee reimbursement of these services in managed care.
- Within the Division of Substance Abuse and Mental Health (DSAMH)
  - 1 FTE to focus on substance use disorder services
  - 1 FTE to focus on mental health services
- Within the Division of Developmental Disabilities Services (DDDS)
  - At least 1 FTE to work with this provider community on all rate updates
- Within the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
  - 1 FTE to work with this provider community on all rate updates
- Within the Division of Management Services (or elsewhere within DHSS)
  - A partial FTE to maintain oversight of rates/policies for services that cross multiple Divisions

Further, although not intended to be considered a definitive list, the table on the next page contains B&A's recommendations for staffing that includes in-house and external resources.

4. ***B&A recommends to all DHSS Divisions that a more formalized Public Notice process be initiated to inform providers and other stakeholders when rate changes are being contemplated***. CMS uses the process of issuing Proposed Rules, then allows for a period of public comment, then issues a Final Rule when rate changes are made. Although it may not need to be as elaborate as the CMS process, DHSS should consider a similar cadence to allow for more transparency on rate changes and communication of DHSS's intent when making changes (e.g., when a value-based component is added to a methodology).

   An example of this process is shown below for a July 1 implementation:

   - *October to December*: Conduct required analysis of any rate changes contemplated
   - *January*: Conduct informal education and discussion with providers
   - *February*: Conduct education with legislators and other stakeholders, as needed
   - *March*: Initiate a formal public notice process of proposed changes (with open period of at least 30 days to allow for public comment)
   - *May*: Respond to formal comments in the public notice process and issue final changes
   - *June*: Release other guidance materials (e.g. updated billing manual) to prepare for implementation

5. Although a Public Notice is helpful, B&A has found that ongoing communication with providers on upcoming rate changes is also essential. Therefore, ***B&A recommends that when rate methodology changes are undertaken, DHSS should build a project-specific work plan that incorporates periodic meetings with the providers affected by the rate change throughout the project***.

6. B&A found that the accuracy and completeness of the manuals that describe the rate methodologies and billing guidance to providers across DHSS were mixed or non-existent. ***B&A recommends that, for each major category of service, there should be a dedicated section in the Provider Manual that describes the rate methodology in detail and that this section is updated timely when any rate changes occur***. As a Department, DHSS should inventory the Provider Manuals currently in the field and use examples from some of the more exemplary manuals as the basis for building the required elements in any Provider Manual.

Specific Staffing Recommendations Tied to Recommendation #3 on the Previous Page

Service Category	Rate Methodology Change Recommended?	External Resources Needed to Change?	Could Internal Resources do Ongoing Maintenance?	Periodicity of Update
General Acute Care Inpatient Hospital	Yes	Yes	Probably yes	Every 4 years
Skilled Nursing/Assisted Living Facilities	Yes	Yes	Probably yes	At least annually
Psychiatric Hospitals	No	N/A	Yes	Annually
Home Health Agencies	Yes	Yes	Yes	Annually
Hospice Care	No	N/A	Yes	Annually
General Acute Care Outpatient Hospital	Yes	Yes	Probably no	Annually
Ambulatory Surgery Centers (ASCs)	No	N/A	Yes	Annually
Dialysis Centers	No	N/A	Yes	Annually
Federally Qualified Health Centers (FQHCs)	Maybe	Maybe	Yes	Annually
Evaluation and Management Services	No	N/A	Yes	Annually
Procedure Services	No	N/A	Yes	Annually
Physician-Administered Drugs	No	N/A	Yes	Annually
Independent Laboratory and Radiology	No	N/A	Yes	Annually
Durable Medical Equipment and Supplies	No	N/A	Yes	Annually
Children's Dental Services	Maybe	Maybe	Yes	Every 2-3 years
Vision and Hearing Services	No	N/A	Yes	Every 2-3 years
Non-Emergency Medical Transportation and Emergency Transportation (Ambulance)	No	N/A	Yes	Every 2-3 years
Private Duty Nursing	Yes	Maybe	Yes	Every 2-3 years
Substance Use Disorder Services Delivered by DSAMH and DMMA	(ongoing now)	Ongoing now	Probably yes	Every 2-3 years
Mental Health Services Delivered by DSAMH	Yes	Yes	Probably yes	Every 2-3 years
Developmental Disability Services Delivered by DDDS	No (recently completed)	N/A	Probably yes	Every 2-3 years
Community Services Delivered by DSAAPD	Yes	Yes	Probably yes	Every 2-3 years

7. ***With respect to opportunities to modernize the rate methodology for HCBS (non-medical services), B&A recommends that DHSS develop a process to capture provider actual costs as well as independent market-based costs to use as a comparison when setting HCBS rates. Rates for these services can be built on a model that is built "from the ground up" and specific to the Division's needs***.

   The services covered in this recommendation pertain most specifically to Division of Developmental Disability Services, the Division of Substance Abuse and Mental Health, the Division of Services for Aging and Adults with Physical Disabilities, and the Division of Social Services for child care support.

There is not a uniform method in which provider costs are captured to deliver HCBS services like there is, for example, with hospitals and nursing facilities. Even when costs can be captured, there is often a "chicken-and-egg" scenario. If the rate of payment is below-market for a service, then the costs that providers will report will be below-market because that is what the provider can afford to spend to remain financially viable.

B&A proposes that, although the rates themselves will differ, the process upon which how rates are developed can be fairly standardized if the following principles are applied for each service:

a) Carefully review the definition of the service and the unit of measurement (e.g., per hour, per day) to ensure the Division is cognizant of what it wants to pay for.
b) Track and maintain if there are specific federal or state rules or policies that must be factored into the cost of delivering the service.
c) Collect cost information from providers to inform the development of a new rate.
d) Collect market-based data *outside of provider costs* to benchmark against the costs reported by providers. For example, a provider's wage costs may be lower than the going market rate because the current rate only supports hourly wages below market.
e) Build and continually updated (such as annually) a "benchmark rate"—that is, what is the rate that could be supported if funds were available. The benchmark rate factors in actual provider costs and market-based conditions (e.g., the continual increase in personnel health insurance costs).
f) When state resources are limited, if the benchmark rate is not affordable, work towards parity to get all services up to a threshold level. This means that it is conceivable that, in any given year, the rates for some services stay constant or even go down while other rates go up. For example, the state can only afford—as a general rule—to pay up to 90% of every benchmark rate. Service #1 already has a rate that is at 93% of the benchmark but Service #2 has a rate at 83% of the benchmark. When rate updates occur, Service #1 does not get a rate increase (or it might even go down) so that the rate for Service #2 can get up to 90% of the benchmark.

Within a service category, B&A recommends that the methodology and approach be consistent to set the rates, but that there may be variations required to account for the following:

- A client's level of need (e.g., support in the home will vary for someone with underlying medical complexities than for someone without these medical conditions);
- The group size (e.g., a 1:1 service is much more expensive than staffing a 1 employee:4 client group);
- The service setting (e.g., in-home or facility-based);
- Staff qualifications or training (e.g., RN vs LPN, licensed psychologist vs peer support);
- Geography (e.g., urban vs rural); and
- Provider supply (e.g., if providers are limited in a specific area of the state to meet the need)

B&A recommends that the following costs always be captured for consideration in the development of rates for HCBS:

- Direct worker wages
- Direct worker benefits
- Direct worker productivity (e.g., how much of an 8-hour day is client facing versus travel time, record keeping, attending training, etc.)
- Program support (e.g., the non-labor costs specific to deliver the service which could include building, vehicles, supplies)
- Administration (e.g., back office costs)

It should be noted that DDDS has adopted this approach for recent updates it has made for services delivered by providers to persons with intellectual and developmental disabilities. Benchmark rates has been developed for each service, but the funding was not available to always set the rate at the benchmark level.

The DMMA has received a federal group to examine the rates paid for delivering services to individuals with substance use disorder. The process described above will be used to assess the rates to pay to providers who deliver these services. The project is just starting in June 2020 with the goal for recommendations to rate changes to be completed by March 2021.

8. Using the theme as described in the prior recommendation, other Divisions can also use this method when entering contract negotiations even if the actual rate is not published. ***B&A recommends that Divisions that use the contracting method to pay providers to develop a rate corridor that they are willing to accept from providers in the bid process that is driven by market data***.

   In other words, Divisions that do not publish fee schedules per se can still use the benchmarking method to determine the range of acceptable rates offered by a bidder that they would accept under a specific service contract. Prior to accepting a provider's proposed rate, the Divisions could conduct research to "build up" the cost components of a rate to determine this acceptable range. Further, any opportunities where a value-based component such as performance targets should be explored that may influence the final rate negotiated with the provider. The Division may or may not choose to publish what this acceptable rate range would be.

   This approach is most likely appropriate for the Division of Public Health, the Division of State Service Centers, the Division for Visually Impaired, and the Division of Social Services for services other than child care support.

9. With respect to services covered by the Division of Medicaid and Medical Assistance (DMMA), the DMMA has adopted protocols to keep current with Medicare rates and rate methodologies on most of the services that it sets rates for. When this protocol is used, it is often the case that the Medicaid rate is on par or just slightly less than the Medicare rate. An example of this is the annual update for most physician and other professional services.

   Whereas the DMMA has built more refinement and processes into the services that it is responsible for than some of the other Divisions, B&A does offer some specific recommendations related to the methodology for some acute health care services:

   - ***For inpatient hospital services, DHSS should consider changing its reimbursement methodology from a per discharge rate that is not based on patient acuity to a per discharge rate based on patient acuity using a diagnosis related grouping (DRG) system.*** As of late 2018, 37 State Medicaid Agencies pay by DRG. The DMMA does not. CMS has paid for inpatient services in the Medicare program by DRG since 1983. If the DMMA moved to a DRG payment system, B&A recommends that the costs specific to Delaware's hospitals be factored into the calculations of the base rates and relative weights assigned to each DRG. A DRG payment system serves as the building blocks for future value-based components such as an incentive program to reduce hospital readmissions.

   - ***For outpatient hospital services, DHSS should consider changing its reimbursement to a more sophisticated rate structure that incentives value and efficiency such as the Medicare Outpatient Prospective Payment System or 3M's Enhanced Ambulatory Patient Grouping***. Some outpatient hospital services are paid off of a fee schedule, but other services are paid based off of a percentage of what the hospital charges. Each hospital can choose to charge

different amounts, so this means that some services are effectively paid a different rate depending upon which hospital is billing the service. The DMMA could modernize this portion of the payment methodology by using the Medicare or 3M systems that follow the principal of paying for a combined group of related services in an outpatient visit together in one rate versus piecemeal. The Medicare grouper is free and hospitals have operated under this methodology in the Medicare program for 20 years. The 3M grouper is proprietary and would add some cost to the DMMA, its MCOs and the hospitals that would be paid under this grouper.

- ***Although the actual per diem rates paid may differ from Medicare's, DHSS should consider immediately migrating to CMS's new methodology to pay for nursing facilities since the current methodology that has been in place for over 20 years will not be supported by CMS beginning in October 2020***. Since 1998, CMS has paid for nursing facility services on a prospective per diem basis using an acuity adjustment on the per diem that was based on patient assignment to a Resource Utilization Group, or RUG. Critics of this methodology stated that the RUGs were too dependent on capturing the number of therapies delivered and less on the other complexities of a resident's care. Beginning in October 2019, CMS changed its methodology to what is called the Patient-Driven Payment Model (PDPM). The PDPM is based on a new classification system. With the introduction of the new classification system, the instrument used to collect information on patients is changing. With the change in this instrument, the previous RUG classifications will no longer be accurate. Since the RUG classification defines the rate paid to the nursing facility, the rates will also be inaccurate. CMS is phasing out support of the RUG system on September 30, 2020. This requires Medicaid agencies to follow Medicare's new PDPM method or develop an alternative to the former RUG method.