DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

Targeted Case Management Services

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend Title XIX Medicaid State Plan regarding Targeted Case Management (TCM). The Department's proceedings to amend its regulations were initiated pursuant to 29 **Del.C.** §10114 and its authority as prescribed by 31 **Del.C.** §512.

The Department published its notice of proposed regulation changes pursuant to 29 **Del. C.** §10115 in the July 2022 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by August 1, 2022. at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

Effective for services provided on and after July 1, 2022 Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) proposes to amend Title XIX Medicaid State Plan regarding Targeted Case Management (TCM).

Background

In 2017, Delaware added Targeted Case Management (TCM) as an optional Medicaid State Plan Service. At that time, Delaware added two distinct Medicaid target groups comprised of individuals who meet the Delaware DDDS eligibility criteria at *16 DE Admin. Code 2100, Division of Developmental Disabilities Services (DDDS) Eligibility Criteria* and who live in specified settings:

1. individuals living in their own home or family home
2. individuals authorized to receive Residential Habilitation in a provider managed residential setting under the DDDS Lifespan Medicaid Home and Community Based Waiver

Since that time Delaware has established TCM rates for five years using a cost-based rate with cost reconciliation methodology approved by CMS in 2017. Because TCM was a new Medicaid service at that time, the initial rates were established based largely on budgeted cost data and assumptions of Medicaid eligibility and service utilization. The currently approved methodology uses a carry forward adjustment to compensate for differences between estimated and actual costs from the prior period used in the TCM rate calculation. The carry forward adjustment, combined with changes to the service delivery model that have been implemented over time, have resulted in wide swings in the annual TCM rates, despite the actual allowable cost per unit of service being relatively stable after the initial startup phase. These swings make the rates unpredictable and are likely to discourage current and prospective providers from doing business with Delaware Medicaid as a provider of Targeted Case Management. The current reimbursement method relies on prior year costs and limits the state's ability to incorporate demographic, programmatic and policy changes that impact program costs as they occur. To that end, Delaware proposes to replace the current retrospective rate methodology with carry forward adjustment with a prospective fee schedule rate methodology.

Proposed Changes to the Reimbursement Methodology

Effective for dates of service on or after July 1, 2022, Delaware proposes to replace the current retrospective rate structure with carry forward adjustment with a prospective market-based fee schedule rate structure. The new proposed rates will be based on rate assumptions for each component of the rate, instead of historical costs like the current methodology. The new methodology will use wage data from the Bureau of Labor Statistics for the applicable labor market, provider experience and stakeholder feedback to develop a set of rate assumptions. CMS refers to this rate development methodology as a "build-up" approach in its 2017 presentation "Cost Factors and Rate Assumptions Template Training". The proposed change will standardize the reimbursement methodology for both target groups. Whereas the current methodology establishes a separate rate for each provider within a target group, the proposed methodology will compute a single fee schedule rate for each target group. This rate will be paid to all providers serving individuals within that target group, i.e., living in the family home or in a provider-managed residential setting. The rate for each target group will be re-based, and the methodology and all the assumptions will be reviewed, at least every five years. In between re-basing years, the fee schedule rate for each target group will be inflated using the CPI-U inflation index.

Under the proposed methodology, the State will consider the following key cost components necessary to complete all contractually required activities or deliverables:

- Staff wages
- Employee benefits and other employee-related expenses
- Program Support Costs
- Administrative Overhead
- Staff to Client Ratio

At any time during the five-year period, revaluation of the rate is considered as warranted based on provider inquiries or service access considerations.

DDDS expects the proposed change in the reimbursement methodology will result in a more stable and predictable rate structure that will better reflect the dynamics of the labor market and ensure that the state has the requisite provider capacity to ensure beneficiary access to TCM services.

Statutory Authority

- 42 CFR §440.169(b), Targeted Case management services
- 42 CFR §441.18, Case management services, specific requirements
- 42 CFR §447.205, Public notice of changes in statewide methods and standards for setting payment rates
- §1915(g) of the Social Security Act, location and comparability of case management services

Purpose

The purpose of this proposed regulation is to amend the provider qualifications and the reimbursement methodology to enable DDDS to increase provider capacity so that DDDS can maintain desired case load ratios for both target groups and to pay a rate for each target group that incorporates all program components and assures an adequate supply of TCM providers.

Summary of Proposed Changes

Effective for dates of service on or after July 1, 2022, DDDS proposes to amend the provider qualifications and the reimbursement methodology for both target groups.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 440.386 and the state public notice requirements of Title 29, Chapter 101 of the **Delaware Code**, DHSS/DMMA gave public notice and provided an open comment period for 30 days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments were to have been received by 4:30 p.m. on August 1, 2022.

Centers for Medicare and Medicaid Services Review and Approval

The provisions of this state plan amendment (SPA) are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manuals and Communications Update

Also, there may be additional provider manuals that may require updates as a result of these changes. The applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals and/or Delaware Medical Assistance Portal will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding DMAP updates. DMAP updates are available on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/provider

Fiscal Impact Statement

The fiscal note for the reimbursement change is based on historical data for the program trended forward to the rate period using the CPI because the new rate methodology will be a prospective fee schedule.

The following fiscal impact is projected because of the proposed change in reimbursement methodology:

	Federal Fiscal Year 2022	Federal Fiscal Year 2023
General (State) funds	$ 27,086	$ 124,651
Federal funds	$ 47,988	$ 175,641

No Comments Were Received In Response to the Proposed Changes

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the July 2022 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend Title XIX Medicaid State Plan regarding Targeted Case Management (TCM) is adopted and shall be final effective September 11, 2022.

8/12/2022

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Date of Signature Molly K. Magarik, Secretary, DHSS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE
TARGET CASE MANAGEMENT SERVICES FOR

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

A. Target Group - Services shall be provided to participants who (42 CFR §441.18(a)(8)(i) and §441.18(a)(9)):
   1. Meet the eligibility requirements set forth in 16 DE Admin. Code 2100 Division of Developmental Disabilities Services (DDDS) Eligibility Criteria which requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader Willi Syndrome with functional limitations; and,
   2. Have been approved to receive residential habilitation under the Delaware HCBS waiver program DE 0009 administered by the Delaware Division of Developmental Disabilities Services (DDDS) authorized under Section §1915(c) of the Social Security Act

   X Target group includes individuals transitioning to a community licensed and/or certified setting. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between the ages of 21 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter 072500b, July 25, 2000) or individuals receiving services and supports while living in their own or family home.

B. Areas of State in which services will be provided(§1915(g)(1)):
   X Entire State
   _ Only in the following geographic areas: *[Specify areas]*

C. Comparability of Services (§1902(a)(10)(B) and§ 1915(g)(1))
   _ Services are provided in accordance with §1902(a)(10)(B) of the Act
   X Services are not comparable in amount, duration, and scope (§1915(g)(1))

D. Definition of Services (42 CFR §440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Targeted Case Management will be performed by ~~individuals called Support Coordinators hereafter~~ case managers and includes the following assistance:

   1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include functions necessary to inform the development of the person-centered plan:

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D. Definition of Services (42 CFR §440.169) Continued

1. Comprehensive and Periodic Assessments Continued
   i) Obtaining client histories and other information necessary for evaluating and/or reevaluating and recommending determination of the individual's level of care
   ii) Identifying the individual's support needs and providing assistance and reminders related to completing needed documentation for clinical and financial eligibility
   iii) Gathering information from sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual
   iv) Providing necessary education and information to the individual and the individual's family to provide necessary familiarity with the program, requirements, rights, and responsibilities.

   The ~~Support Coordinator~~ case manager collects information to inform the plan and/or directly conducts an assessment of an individual's needs for services prior to waiver enrollment and at least annually thereafter or more frequently at the request of the individual or as changes in the circumstances of the person warrant. This is the frequency of review that is specified in the approved DDDS HCBS waiver.

2. Development (and periodic revision) of a specific person-centered plan in accordance with 42 CFR §441.301(c)(1) through 42 CFR §441.301(c)(4). This activity may be conducted through direct and collateral contacts. The plan must reflect what is important to the individual to lead the life they want to lead. The plan must also reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

   The ~~Support Coordinator~~ case manager:

   i) Uses a person-centered planning approach and a team process to develop the individual's person-centered plan to meet the individual's needs and achieve the individual's goals in the most integrated setting and manner possible
   ii) Provides support to the individual to ensure that the process is driven by the individual to the maximum extent possible and includes people chosen by the individual, with the individual at the center of the process
   iii) Assists the person to select qualified providers who can best meet their needs
   iv) Ensures that the plan identifies risk factors and includes plans to mitigate them
   v) Facilitates transition for new waiver enrollees moving from their family home to a waiver residence

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D. Definition of Services (42 CFR §440.169) Continued
2. Person Centered Plan, ~~Support Coordinator~~ Continued
vi) Facilitates seamless transitions between providers, services or settings for the maximum benefit of the individual
vii) Updates the person-centered plan annually or more frequently, if needed, as the individual's needs change
viii) Provides individuals with information regarding their rights, including related to due process and fair hearings, and providing support to individuals as they exercise those rights and
ix) Obtains necessary consents.

3. Information, referral, facilitating access and related activities to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

The ~~Support Coordinator~~ case manager:

i) Assists individuals and families in gaining information and establishing linkages with peers, professionals or organizations who can be key informants in supporting individuals with disabilities throughout the life course
ii) Explores coverage of services to address individuals' needs through a full array of sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources
iii) Collaborates and coordinates with other individuals and/or entities essential in the delivery of services for the individual, such as MCO representatives, vocational rehabilitation and education coordinators to ensure seamless coordination among needed support services and to ensure that the individual is receiving services as appropriate from other sources
iv) Coordinates with providers and potential providers to ensure seamless service access and delivery
v) Facilitates access to financial assistance, e.g. Social Security benefits, SNAP, subsidized housing, etc.
vi) Facilitates continued enrollment in the DDDS HCBS Waiver by gathering or completing necessary documentation
vii) Assists individuals in transitioning to and from the Diamond State Health Plan Plus Medicaid LTSS benefit
viii) Assists an individual to access legal services

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D. Definition of Services (42 CFR §440.169) Continued
3. Information, referral, facilitating access and related activities, ~~Support Coordinator~~ Continued
i) May assist an individual to obtain transportation to appointments and other activities.
ii) Informs and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship.
iii) Facilitates referral to a nursing facility when appropriate and when other available options have been fully considered and exhausted.
iv) Participates in transition planning for an individual's discharge from a nursing facility or hospital within six months of the planned discharge date

4. Monitoring and follow-up activities and contacts are provided as necessary to ensure the person-centered plan is implemented and addresses the eligible individual's needs and the individual and individual's family's vision for the future. Monitoring ensures that: Monitoring and follow-up activities that include activities and contacts that are necessary to ensure the person-centered plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals. The contacts are conducted as frequently as necessary, in accordance with a minimum frequency as specified in the approved HCBS waiver application, to determine whether the following conditions are met:

   i) Services are being furnished in accordance with the individual's person-centered plan
   ii) Services in the person-centered plan are adequate and
   iii) Changes in the needs or status of the individual are reflected in the person-centered plan

   Monitoring and follow up activities include making necessary adjustments in the person-centered plan and service arrangements with providers, including:

   i) Monitoring of the health and welfare of the individual through monthly contacts that can include face-to-face, telephone or email contacts with the recipient or on behalf of the recipient, taking into account the communication preferences of the individual/guardian and incorporating the results into revisions to individual service plans as necessary to ensure that the individual can meet his or her goals
   ii) Activities and contacts necessary to ensure that the individual service plan is effectively implemented and adequately addresses the needs of the eligible individual
   iii) Ensuring that services are provided in accordance with 42 CFR §441.301(c)(4)
   iv) Providing advocacy on behalf of individuals to ensure receipt of services as indicated in their person-centered plan

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TARGET CASE MANAGEMENT SERVICES FOR
Individuals with Intellectual and Developmental Disabilities Approved for Funding through the Delaware DDDS HCBS Waiver Program DE 0009 Who Are Authorized to Receive Residential Habilitation

D. Definition of Services (42 CFR §440.169) Continued
   4. Monitoring and Follow-up Continued
      v) Responding to and assessing emergency situations and incidents and ensuring that appropriate actions are taken to protect the health, welfare, and safety of the individual
      vi) Participating in planning meetings to address individual crisis needs, discuss options, and ensure that an action plan is developed and executed
      vii) Assessing whether the individual's crisis is being mitigated, and following up when appropriate through contact with the individual and any service providers
      viii) Reviewing provider documentation of service provision and monitoring individual progress on goals identified in the person-centered plan, and initiating contact when services are not achieving desired outcomes
      ix) Participation in investigations of reportable incidents and integrating prevention strategies into revisions to individual service plans as necessary to remediate individual and systemic issues
      x) Ensuring that services are provided in accordance with the individual service plan and individual service plan services are effectively coordinated through communication with service providers
      xi) Activities and contacts that are necessary to ensure those individuals and their families (as appropriate) receive appropriate notification and communication related to unusual incidents and major unusual incidents
      xii) Soliciting input from the individual and/or family, as appropriate, related to their satisfaction with the services

      X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying

needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. 42 CFR §440.169(e)).

Provider Qualifications (42 CFR §441.18(a)(8)(v) and 42 CFR §441.18(b)

~~The State of Delaware, Division of Developmental Disabilities Services (DDDS) in the Department of Health and Social Services (DHSS) shall be the entity enrolled to provide Targeted Case Management to this target group.~~

~~Qualified Support Coordinators shall include state employees determined by DDDS to have the requisite expertise to be able to support individuals with intellectual and developmental disabilities. The Support Coordinator must have knowledge about services to persons with intellectual and developmental disabilities; knowledge of the interdisciplinary approach to person centered planning, skill in facilitating positive group processes, the ability to translate clinical and other assessments and recommendations into program activities and the ability to develop realistic objectives for each service.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE
TARGET CASE MANAGEMENT SERVICES FOR
Individuals with Intellectual and Developmental Disabilities Approved for Funding through the Delaware DDDS HCBS Waiver Program DE 0009 Who Are Authorized to Receive Residential Habilitation

Qualified providers must have a contract or other written agreement with the State of Delaware that specifies requisite expertise in supporting individuals with intellectual and developmental disabilities and their families.

Specifically, the ~~Support Coordinators~~ providers will comply with DDDS and Department of Health and Social Services (DHSS) standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Individuals providing this service must:

1. Have an Associate's degree or higher in behavioral, social sciences, or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements;

Provider Qualifications (42 CFR §441.18(a)(8)(v) and 42 CFR §441.18(b) Continued

2. Have demonstrated experience and competency in supporting families
3. Complete ~~Department~~ DDDS and DHSS required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include but is not limited to: communication, mobility and behavioral support needs
4. Comport with other requirements as required by ~~the Department~~ DDDS and DHSS.

Freedom of Choice (42 CFR §441.18(a)(1)

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in the plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR §441.18(b))

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are

limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

The providers of services under this authority are limited to designated state staff with necessary knowledge, skills and abilities to effectively provide TCM to individuals within the target group. The state ensures that all individuals within the target group will receive unfettered access to these services.

TN No. SPA	Approval Date
Supersedes	
TN No. #16-011	Effective Date

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
For Targeted Case Management services for Individuals Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family's Home

Monthly Rate:

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

- ~~Practitioner salary, consistent with the minimum state case manager qualifications for this service.~~
- ~~Employment Related Expenses including fringe benefits and taxes, paid time off and training.~~
- ~~Program Indirect Expenses necessary for the provision of TCM services including supervision, technology, quality assurance and allowance for non-productive time.~~
- ~~Practitioner Transportation costs (not to include transportation of consumers).~~
- ~~General and Administrative Cost necessary for the provision of TCM services limited to 12 %.~~
- ~~Statistically valid time study data is used to determine the proportion of total cost that represents a Medicaid allowable activity.~~

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

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

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

A routine review of the rate methodology has led the State to conclude that a prospective market-based fee schedule rate is more consistent with efficiency, economy, and quality of care than a retrospective rate with carry forward adjustment because it will result in more stability and predictability for the TCM rate. Effective July 1, 2022, the rate methodology will be changed to a prospective fee schedule rate based on rate assumptions instead of actual costs.

To develop the fee schedule rate, the state considers the following key cost components necessary to complete all contractually required activities or deliverables:

- Staff wages
- Employee benefits and other employee-related expenses
- Productivity
- Program Support Costs
- Administrative Overhead

- Staff to Client Ratio

To model the cost components, various market sources are reviewed, including staff wages and benefits for the local labor market from the U.S. DOL Bureau of Labor Statistics, provider experience and other stakeholder feedback. The market assumptions for each component are factored together to develop an overall hourly rate, which is then converted to a monthly rate.

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The State will rebase the rate and re-examine all the rate assumptions and the overall methodology at least every five years. In years in which the rate is not rebased, the annual rate will be adjusted for inflation using the average CPI-U Inflation Index for the most recent twelve months available. If the CPI-U adjustment indicates a negative adjustment for the 12-month period, no change shall be made to the TCM rate. At any time during the five-year period, revaluation of the rate is considered as warranted based on provider inquiries or service access considerations.

The state payment for TCM will be the lower of:
- The provider's submitted charge for the service
- The DDDS fee schedule rate

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

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

The fee schedule rate was set as of ~~4/1/2017~~ 7/1/2022 and is effective for service provided on or after that date.

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both government and private providers. The fee schedule and any annual/periodic adjustments to the fee schedule are available on the DDDS website at the following link:

https://dhss.delaware.gov/dhss/ddds/ddds_rates.html

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
For Targeted Case Management services for Individuals with Intellectual and Developmental Disabilities Approved for Funding through the Delaware DDDS HCBS Waiver Program DE 0009 Who Are Authorized to Receive Residential Habilitation

Monthly Rate:

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

~~captures costs for the following cost categories:~~

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

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

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

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

A routine review of the rate methodology has led the State to conclude that a prospective market-based fee schedule rate is more consistent with efficiency, economy and quality of care than a retrospective rate with carry forward adjustment because it will result in more stability and predictability for the TCM rate. Effective July 1, 2022, the rate methodology will be changed to a prospective fee schedule rate based on rate assumptions instead of actual costs.

To develop the fee schedule rate, the state considers the following key cost components necessary to complete all contractually required activities or deliverables:

- Staff wages
- Employee benefits and other employee-related expenses
- Productivity
- Program Support Costs
- Administrative Overhead
- Staff to Client Ratio

To model the cost components, various market sources are reviewed, including U.S. DOL Bureau of Labor Statistics wages and benefits, provider experience and other stakeholder feedback. The market assumptions for each component are factored together to develop an overall hourly rate, which is then converted to a monthly rate.

The State will rebase the rate and re-examine all the rate assumptions and the overall methodology at least every five years. In years in which the rate is not rebased, the annual rate will be adjusted for inflation using the average CPI-U Inflation Index for the most recent twelve months available. If the CPI-U adjustment indicates a negative adjustment for the 12-month period, no change shall be made to the TCM rate. At any time during the five-year period, revaluation of the rate is considered as warranted based on provider inquiries or service access considerations.

The state payment for TCM will be the lower of:

- The provider's submitted charge for the service
- The DDDS fee schedule rate

A unit of service shall:
(a) Be one (1) month; and

(b) Consist of a minimum of one (1) service contact that can include face-to-face, telephone or email contacts with the recipient or on behalf of the recipient.

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

The fee schedule rate was set as of ~~12/31/16~~ 7/1/2022 and is effective for services provided on or after ~~1/1/2017~~ that date.

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both government and private providers. The fee schedule and any annual/periodic adjustments to the fee schedule are available on the DMAP website at the following link:

https://dhss.delaware.gov/dhss/ddds/ddds_rates.html