4.19(d) Nursing facility payment rates are based on Maryland regulations COMAR 10.09.10 in order to account for the cost of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid benefits. Payment rates for nursing facilities are the sum of per diem reimbursement calculations in 4 cost centers: administrative/routine, other patient care, capital, and nursing service; and payment for therapy services. Payments in the aggregate may not exceed Medicare upper limits as specified at 42 CFR 447.272.

In accordance with the Omnibus Budget Reconciliation Act of 1987, nursing facility payment rates, effective October 1, 1990, take into account the costs of nursing facilities' compliance with the requirements of Sections 1919(b) (other than paragraph (3)(F)), 1919(c), and 1919(d) of the Social Security Act.

During the State fiscal year beginning July 1, 2009, rates shall remain unchanged from those in effect during the period November 1, 2008 through June 30, 2009. Effective August 1, 2009 through November 30, 2009, these rates shall be reduced by increasing the net reduction in Administrative/Routine, Other Patient Care, and Capital cost center payments from 4.816 percent to 8.681 percent. Effective December 1, 2009, these rates shall be increased by decreasing the net reduction in Administrative/Routine, Other Patient Care, and Capital cost center payments from 8.681 percent to 7.796 percent.

Nursing facilities that are owned and operated by the State are not paid in accordance with the provisions described below, but are reimbursed reasonable costs based upon Medicare principles of reasonable cost as described at 42 CFR 413. Aggregate payments for these facilities may not exceed Medicare upper payments limits as specified at 42 CFR 447.272.

Administrative/Routine Costs

The Administrative/Routine cost center includes the following expenses: administrative, medical records, nurse aide registry fees, training, dietary, laundry, housekeeping, operation and maintenance, and capitalized organization and start-up costs. There are 3 reimbursement groups in this cost center; based on geographic location, as specified under COMAR 10.09.10.24A (which is appended to this attachment).

Provider's per diem costs are calculated at the actual occupancy of the nursing facility beds or at the Statewide average occupancy of nursing facility beds plus 2 percent, whichever is higher, for the calculation of ceilings, current interim costs and final costs.

Although an interim Administrative/Routine rate is calculated for each provider, based on indexed cost report data, the final per diem reimbursement rate, after cost settlement, is the sum of:

(1) The provider's allowable per diem costs for covered services according to the principles of reasonable cost reimbursement established under 42 CFR Part 413, subject to the ceiling calculated for the provider's reimbursement class, and

(2) For those providers with costs below the ceiling, an efficiency allowance equal to 40 percent of the difference between the ceiling and the provider's costs, subject to a cap of 10 percent of the ceiling.

The interim per diem rates for the Administrative/Routine cost center is the sum of:

(1) The provider's indexed per diem costs subject to the ceiling calculated for the provider's reimbursement group, and

(2) For those providers with projected costs below the ceiling, 90 percent of the efficiency allowance as calculated above.

Ceilings are calculated for each of the 3 reimbursement groups. Each year all providers enrolled in the Program are required to submit a cost report within 3 months of their fiscal year end. Current administrative and routine costs are adjusted, using indices established under COMAR 10.09.10.20 (which is appended to this attachment), by indexing them from the mid-point of the provider's fiscal year to the midpoint of the State's fiscal year for which rates are being established. Indexed per diem costs are calculated by dividing indexed expenses by total days of care. The indexed per diem costs for Maryland providers are then weighted by their associated paid Medical Assistance days and the median per diem costs for each reimbursement group is determined. The maximum per diem rate is 112 percent of the median cost in each group. The ceilings are applied, as described above, to determine each provider's interim per diem payment.

Providers that maintain kosher kitchens and have administrative and routine costs in excess of the ceiling that are attributable to dietary expense, shall receive an add-on to its interim and final per diem payments in an amount up to 15 percent of the median per diem cost for dietary expense in its reimbursement group.

For the period November 1, 2008 through July 31, 2009, the interim and final per diem rates in the Administrative/Routine cost center are reduced by 4.816 percent and, for the period August 1, 2009 through November 30, 2009, 8.681 percent, in order to meet State budget requirements. Effective December 1, 2009, these rates shall be increased by decreasing the net reduction in payments from 8.681 percent to 7.796 percent.

Other Patient Care Costs

The Other Patient Care cost center includes expenses for providing: a medical director, pharmacy, recreational activities, patient care consultant services, raw food, social services and religious services. There are 3 reimbursement groups in this cost center, based on geographic location, as specified under COMAR 10.09.10.24 (which is appended to this attachment). Both the final per diem and interim per diem rates for the Other Patient Care cost center are determined as are those in the Administrative/Routine cost center. (Indices for Other Patient Care are established under COMAR 10.09.10.21 which is appended to this attachment.) Ceiling calculations are also

identical except that the maximum per diem rate is 118 percent of the projected per diem cost in each group. For providers with costs below the ceiling, the efficiency allowance is 25 percent of the difference between the ceiling and the provider's costs, subject to a cap of 5 percent of the ceiling.

Providers that maintain kosher kitchens and have other patient care costs in excess of the ceiling that are attributable to raw food expense, shall receive an add-on to its interim and final per diem payments in an amount up to 15 percent of the median per diem cost for raw food expense in its reimbursement group.

For the period November 1, 2008 through July 31, 2009, the interim and final per diem rates in the Other Patient Care cost center are reduced by 4.816 percent and, for the period August 1, 2009 through November 30, 2009, 8.681 percent, in order to meet State budget requirements. Effective December 1, 2009, these rates shall be increased by decreasing the net reduction in payments from 8.681 percent to 7.796 percent.

A facility's net capital value rental per diem component is calculated as follows. At a minimum of every 4 years, each facility's building(s), nonmovable equipment and land are appraised. Using indices established by regulation, these appraisal amounts are indexed to the midpoint of the State fiscal year for which rates are being set. (Building value and nonmovable equipment are indexed by Quarterly Index for Construction, Baltimore, from Marshall Valuation Service - mean of indices for reinforced concrete and masonry bearing walls. Land value is indexed by Maryland land value statistics from the Bureau of Appraisal Review, Office of Real Estate, State Highway Administration, Department of Transportation. See COMAR 10.09.10.22 which is appended to this attachment.) The per bed value is subject to a ceiling which is established in accordance with COMAR 10.09.10.10G(4) (which is appended to this attachment.) The resulting allowable per bed value is then increased by adding an equipment allowance, which is also indexed each year based on indices set in regulation. (Quarterly Index for Hospital Equipment from Marshall Valuation Service. See COMAR 10.09.10.22 which is appended to this attachment.) The facility's allowable debt, that amount that does not exceed allowable capital value, is subtracted from the allowable capital value to arrive at the facility's net capital value. Net capital value is multiplied by the appropriate rental rate established at COMAR 10.09.10.10G(9) (which is appended to this attachment) to arrive at the provider's total net capital value rental. The per diem payment is derived by dividing this amount by the actual occupancy of the nursing facility beds plus 95 percent of licensed capacity of the non-nursing facility beds, or the Statewide average occupancy of nursing facility beds plus 2 percent, plus 95 percent of licensed capacity of the non-nursing facility beds, whichever is higher.

For leased facilities, the above procedure is modified as follows. A debt amount is calculated based on the assumptions that the original portion mortgaged was equal to 85 percent of the appraised value at the time the provider's original lease for the facility was executed, and that the mortgage was taken for a 20 year period with amortization calculated with constant payments. A mortgage interest rate is calculated using indices established at COMAR 10.09.10.10D (which is appended to this attachment).

A facility's recurring capital cost per diem component is calculated as follows. The sum of all recurring costs: taxes, insurance, allowable interest (interest on mortgage debt that does not exceed the facility's allowable capital value) and central office capital costs, are divided by actual occupancy of the nursing facility beds or the Statewide average occupancy of nursing facility beds plus 2 percent, whichever is higher. For leased facilities, taxes and insurance costs are included whether paid by the lessor or the lessee.

For the period November 1, 2008 through July 31, 2009, the interim and final per diem rates in the Capital cost center are reduced by 4.816 percent and, for the period August 1, 2009 through November 30, 2009, 8.681 percent, in order to meet State budget requirements. Effective December 1, 2009, these rates shall be increased by decreasing the net reduction in payments from 8.681 percent to 7.796 percent.

The interim capital per diem payment is subject to final reconciliation at cost settlement.

Regional fringe benefit factors are applied to the wages of all non-agency staff. Then, for each nursing region and occupation group, the wage rate at the 75th percentile of hours worked is selected. These selected wages are indexed to the midpoint of the rate year, using salary and wage indices specified under COMAR 10.09.10.23 (which is appended to this attachment). These adjusted wages are used as the foundation for calculating nursing rates for the ADL classifications and ancillary procedures.

Each ADL classification and ancillary procedure requires a specific amount of nursing staff time per day, based upon a work measurement study and staffing information from the wage survey. These data also determine the percentage of time each occupation group is involved in each ADL classification and procedure.

Reimbursement for the nursing time required for the ADL classifications and ancillary procedures is calculated by multiplying the daily hours required by the personnel category weight, multiplying the product by that personnel category's adjusted wage, and summing the results for each level of care and procedure in each nursing region.

As an incentive for providers to serve heavier care patients, this nursing time rate for specified ADL classifications and procedures is modified by multiplying the rate by an incentive factor as listed below.

Level of Care/Procedure	Incentive Factor
Light Care	0.97
Moderate Care	1.02
Heavy Care	1.03
Heavy Special Care	1.04
Decubitus Ulcer Care	1.04
Tube Feeding	1.04
Communicable Disease Care	1.04
Central Intravenous Line	1.04
Peripheral Intravenous Care	1.04
Ventilator Care	1.04

The above described "nursing time rates" (not including the amount of the incentive factors) are also subjected to the following adjustments:

OS Notification

State/Title/Plan Number:	**Maryland 10-002**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**July 21, 2010**
Fiscal Impact in Millions:	**FY 2010 $0** **FY 2011 $0**

Number of Potential Newly Eligible People: 0
Eligibility Simplification: No
Provider Payment Increase: No
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

This amendment makes offsetting changes to NF payments. It increases NF rates by decreasing the net reduction factor for the Administrative/Routine, Other Patient Care, and Capital cost centers of the reimbursement rate to 7.796% (from the current 8.681%) beginning December 1, 2009. The offset is attained by implementing a Light Care level of care incentive factor of 0.97.

Maryland estimates $0 impact as a result of these changes. Non-Federal share is provided through general fund appropriations and revenue from a CMS approved provider tax. MD provided an acceptable NF UPL demonstration.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and the approval of the SPA is not in violation of the ARRA provisions.

Non Federal Share:	**State appropriations & approved provider taxes**
CMS Contact:	**Gary Knight (304) 347-5723** **National Institutional Reimbursement Team**