STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Item 1 – For all dual Medicare and full Medicaid covered individuals (note: does not apply to QMB-only), the coinsurance payment for outpatient psychiatric services is the Medicare allowable amount, including any amount normally withheld as a psychiatric exclusion, less the amount paid by Medicare. The deductible payment will be the deductible amount determined by Medicare.

Item 2 – Payment for Part A coinsurance days for dually eligible nursing home recipients is the difference between the amount that Medicare paid and the Medicaid per diem statewide average payment for Nursing Facility Services up to a ceiling of the current coinsurance per diem rate as established by the Department of Health and Human Services.

Item 3 – For all dual Medicare and full Medicaid covered individuals, and QMB-only individuals, the coinsurance payment for Part B claims is the difference between the amount that Medicare paid and the Medicaid allowable-amount* up to the full Medicare coinsurance amount with the exception of Item 1 above and:

- Five-digit HCPCS Level II codes that begin with a letter of the alphabet – Medicaid will defer to Medicare pricing for these codes
- Anesthesiology services identified by 00100 to 01999 in the CPT coding book – Medicaid will defer to Medicare pricing for these codes
- Codes that are priced by report – certain codes cannot be priced in the computer system because they must be priced on a case by case basis - Medicaid will defer to Medicare in pricing for these codes
- Services only covered by Medicare – Medicaid will defer to Medicare pricing for these services
- Services provided by FQHCs - Medicaid will defer to Medicare pricing for these services
- Codes that have a Medicare modifier that is not recognized by Medicaid – sometimes Medicare has payment logic built into modifiers that we do not have in the Medicaid program –Medicaid will defer to Medicare pricing logic

* For professional fees for Medicaid recipients under the currently approved State Plan, the State pays approximately 80% of Medicare, but there are some codes where Medicaid pays up to 100% of Medicare or slightly less based on the need to attract certain specialists (example – obstetricians). Under the new methodology described in Item 3, Maryland Medicaid will only

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pay up to what Medicaid would have paid for the procedure code, but in no case more than what Medicare would have paid for the code. For example, if the Medicare rate for the code were $100 and the Medicaid rate was $80, Medicare would pay $80 and Maryland Medicaid would pay nothing because we only pay up to the Medicaid rate. If the Medicare rate were $100 and our rate for the code was $90, then Medicare will pay $80 and Maryland Medicaid will pay $10.