STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

2.a. OUTPATIENT HOSPITAL SERVICES

1. All hospitals located in Maryland which participate in the Program and are regulated by the All Payer Hospital Rate System, except those listed in 2 through 6 below, will charge--and payers will reimburse--according to rates approved by the HSCRC, pursuant to the HSCRC statue and regulation. Under this system, all regulated hospitals are required to submit to the HSCRC base year data using a uniform accounting and reporting system. The HSCRC establishes approved rates for units of service in the various revenue producing departments (rate centers). The rates include adjustments for such items as inflation, volume changes, pass-through costs, and uncompensated care. A description of the HSCRC's uncompensated care methodology is described in Attachment 4.19A Section I. A. The HSCRC posts each hospital's rates by rate center on the HSCRC's website: http://www.hscrc.state.md.us/index.cfm

2. The Program will make no direct reimbursement to any Maryland State-operated chronic hospital, or psychiatric hospital.

3. An acute general or special hospital not located in Maryland or DC will be paid the host State Medicaid rate.

4. Beginning with fiscal year 2007, private freestanding pediatric rehabilitation hospitals in Maryland not approved for reimbursement according to the HSCRC rates, shall be reimbursed for outpatient expenditures using a prospective rate which is calculated based on the lower of cost from the Medicare 2552 Cost Report or up to 100% of outpatient charges. The percentage of charges reimbursed is adjusted annually by increasing the audited 2004 Medicare 2552 cost report trended forward times the Outpatient Prospective Payment System market basket update factor.

5. Psychiatric Hospitals Outpatient costs are reimbursed based on Medicare's retrospective cost reimbursement principles utilizing the Medicare cost report. The percentage of charges is calculated by taking outpatient charges divided by outpatient cost.

   a. Medicare standards for retrospective cost reimbursement described in 42 CFR Part 413 as filed in the Medicare 2552 cost report; or

   b. On the basis of charges if less than reasonable cost.

   In calculating retrospective cost reimbursement rates, the Program or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, or groups of costs, or costs of specific groups of patients. When the cost, or group, or groups of costs, designated, cover services rendered to all patients, including MA recipients, operating costs applicable to all patients will be reduced by the amount of the restricted grants, gifts, or income from endowments thus resulting in a reduction of allowable costs.

6. D.C. Outpatient

A hospital located in D.C. for outpatient services shall be paid a percentage of charges based on the result of **multiplying** the Factors 1 and 2 then **adding** Factor 3 as follows:

- Factor 1 is the report period cost-to-charge ratio. This factor, which is determined by an analysis of the hospital's most recent Medicare 2552 cost report as filed by the Maryland Medical Assistance Program or its designee, establishes the cost-to-charge ratio for the hospital during the cost report period.

- Factor 2 is the cost-to-charge projection ratio. This factor, which is determined by an analysis of the hospital's three most recent cost reports performed by the Program or its designee, projects the cost-to-charge ratio from the cost report periods two years prior to the latest cost report to the prospective payment period. The annual rate of change is applied from the mid-point of the report period used to develop Factor 1 to the mid-point of the prospective payment period. To reflect the accelerating pace of cost-to-charge ratio decreases, Factor 2 shall not be greater than 1.000.

- Factor 3: Beginning July 1, 2011 rates calculated according to Factor 1 and 2 above will be adjusted upward by 2.0 percentage points.

2.b. RURAL HEALTH CLINIC SERVICES

RHCs and FQHC services are considered the same. Reimbursement is listed in Section 2.c. below

2.c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Federally qualified health center (FQHC), Rural Health Centers (RHCs), and other ambulatory services furnished by these facilities are cost-based and facility-specific. Subparagraphs (1) through (5) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

1) Effective for dates of service occurring January 1, 2001 and after, FQHCs/RHCs were reimbursed on a prospective payment rate. The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the clinic's fiscal years 1999 and 2000. The rates for the FQHCs/RHCs were adjusted annually by the percentage increase in the Medicare Economic Index (MEI).

2) As of January 1, 2005, the Department implemented an Alternative Payment System (APS). As of January 1, 2010 all existing FQHCs/RHCs elected to be reimbursed with the APS.

   a) The payment rate under the APS for covered FQHC/RHC services furnished to Medicaid beneficiaries is equal to 100 per cent of their average reasonable costs.

   b) Reimbursement shall occur on a per-visit basis with one rate for primary care and another for dental. For both services, providers will be grouped as urban or rural centers.

   c) A "visit" is defined as a face-to-face encounter between the patient and any health professional whose services are reimbursed under the State Plan during which an FQHC/RHC service is rendered.

   d) An FQHC/RHC service includes concerns for: somatic issue, dental, mental health, and/or substance abuse services. Additionally, a provider my bill for a visit on the same day, same location in cases when the patient, subsequent to the first visit for a somatic service suffers an illness or injury requiring additional diagnosis or treatment.

   e) Allowable costs will be determined in accordance with Medicare principles of reasonable cost reimbursement as contained in 42CFR 413 Subparts A-G.

   f) Allowable costs relating to covered Maryland Medical Assistance services are included in the federally qualified health center's reimbursement methodology and will continue to be used in the calculation of the baseline rate.

   g) The rates are adjusted annually to reflect the increase or decrease in the Medicare Economic Index (MEI).

   h) Rates paid under this cost based reimbursement methodology must be at least equal to the payment under the payment methodology included in subparagraph (1).

   i) Under the APS, the FQHCs/RHCs are paid their full per-visit rate by the Managed Care Organization (MCO) when the service is rendered.

3) Newly qualified FQHCs/RHCs established after January 1, 2001, will have their rates established in the following manner.

   a) The FQHC/RHC shall be assigned an interim rate for the first three years of operation that is the average of current FQHC/RHC urban or rural rates.

   b) The Department or its designee shall request from the FQHC/RHC, cost reports for the first 2 fiscal years of operation.

   c) The Department or its designee shall calculate a final rate that is an average of the first two fiscal years of operation. The final rate is equal to 100% of their average reasonable costs.

   d) The Department will reconcile the interim rate to the final rate for the FQHC/RHC.

4) In the event that the provider elects to institute a scope of services change, the provider shall:

   a) Notify the Department of its intent to institute the scope of services change not later than 30 days before it begins to deliver services under the scope of services change.

   b) The FQHC/RHC shall notify the Department of the change of scope. The FQHC/RHC may request a rate revision based on the change of scope of services. The FQHC/RHC must submit a cost report and supporting documentation within 90 days after the end of the first one-year period immediately following the implementation of the scope of services change. The cost report should reflect the change in costs relating to the rate revision request due to the implementation of the change of scope of services.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☐ No limitations ☒ With limitations*

2. a. Outpatient hospital services.

   Provided: ☐ No limitations ☒ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the state plan.

   Provided: ☐ No limitations ☒ With limitations*

   ☐ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ☐ No limitations ☒ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

Provided: ☒ No limitations ☐ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ☐ No limitations ☒ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

b. Optometrists' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Chiropractors' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

d. Other practitioners' services.

[X] Provided Identified on attached sheet with description of limitations, if any.

[ ] Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: [ ] No limitations [X] With limitations*

b. Home health aide services provided by a home health agency.

Provided: [ ] No limitations [X] With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations*
[ ] Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

\+ ++
[X] Provided: [ ] Additional coverage

b. Services for any other medical conditions that may complicate pregnancy.

\+ ++
[X] Provided: [ ] Additional coverage
[ ] Not Provided.

c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a) (10) (A) (ii) (IX) of the Act.

\+ ++
[X] Provided: [ ] Additional coverage
[ ] Not Provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

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State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

23. Certified pediatric or family nurse practitioners' services.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided in attachment.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

ENHANCED SERVICES FOR PREGNANT AND POSTPARTUM RECIPIENTS

Under the authority of section 1902(a) (10) (E), making available enriched services relating to pregnancy (including prenatal, pregnant and delivery, or postpartum services) or to any other condition which may complicate pregnancy. The services are available to a pregnant recipient or postpartum recipient who is certified for and is receiving Medical Assistance benefits, enters the Healthy Start Program during a medically verified pregnancy or up to 60 days after the delivery, may continue in the program receiving postpartum-family planning services up to 60 days after the delivery, and elects to receive Healthy Start services.

ENHANCED SERVICES FOR PREGNANT AND POSTPARTUM RECIPIENTS

Definition of Services:

Healthy Start Program means a program designed to identify and address medical, nutritional, and psychosocial predictors of poor birth outcomes and poor child health by providing enhanced prenatal and postpartum services for pregnant and postpartum female recipients and enhanced follow-up services to identify high-risk infant and child recipients.

1. Risk Assessment - Plan of Care means a package of services provided to a pregnant participant by or under the supervision of a physician or nurse-midwife in conjunction with the clinical services provided by the physician or nurse-midwife. One unit of service is to be reimbursed for each pregnancy. The services include:

   a. A Risk Assessment is a comprehensive appraisal of the participant's medical history and current health, nutritional, psychological, and social status, as specified in the Healthy Start Risk Assessment Instrument.

   b. A Plan of Care is a description of the services and resources required to meet the participant's needs identified through the risk assessment.

2. Enriched Maternity Service means direct counseling, educational, case coordination, and referral services provided to all pregnant or postpartum recipients by or under the supervision of a physician or certified nurse-midwife in conjunction with the clinical services provided by the physician or nurse-midwife during each prenatal or postpartum visit.

   The following components comprise Enriched Maternity Service:

   a. Prenatal and postpartum counseling and health education for all pregnant and postpartum participants.

   b. Nutrition education for all pregnant and postpartum participants including the benefits of the Special Supplemental Food Program for Women, Infants and Children (WIC).

   c. Case coordination and referral for all pregnant participants.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

ENHANCED SERVICES FOR PREGNANT AND POSTPARTUM RECIPIENTS

3. High-Risk Nutritional Intervention Services means one-on-one counseling and educational services provided to nutritionally high-risk pregnant participants by a qualified dietitian or nutritionist.

Dieticians and nutritionists must be licensed to practice in the jurisdiction in which services are provided.

a) Making a nutritional assessment;
b) Developing an individualized nutritional care plan;
c) Determining appropriate intervention to achieve care plan goals; and
d) Monitoring and recording the participant's progress toward goal achievement.

STATE PLAN FOR MEDICAL ASSISTANCE
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Description of Services: INPATIENT SERVICES

Medically necessary services that require admission in an acute, chronic, or psychiatric hospital.

Provider Types:

"Hospital" refers to Maryland Licensed institutions that meet the standards of CFR §440.10.

Limitations:

Reimbursement will not be made for any services identified by the Department as not medically necessary or not covered.

Preauthorization by the Department's Utilization Control Agent is required for all non-emergency admissions except deliveries. If a delivery stay exceeds 3 days, preauthorization is required for day 4 through discharge for the mother and day 6 through discharge for the newborn.

Concurrent review is also required for all hospital stays for Medicaid recipients.

STATE PLAN FOR MEDICAL ASSISTANCE
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STATE OF MARYLAND

2.a **Description of Services**: OUTPATIENT SERVICES

Medically necessary services that are diagnostic, curative, palliative, or rehabilitative treatment that are available in an acute, chronic, or psychiatric hospital but that do not medically necessitate admission.

Provider Types:

"Hospital" refers to Maryland Licensed institutions that meet the standards of CFR §440.20(a).

Limitations

Includes but is not limited to:

- Any service not medically necessary.
- Sterilizations if not performed according to criteria contained in 42 C.F.R. §441.250-441.259, and if the appropriate Departmental forms, as established by guidelines, are not properly completed.
- Services or drugs that are experimental or investigational.
- Immunizations for travel.

Preauthorization is required for Mental health services.

STATE PLAN FOR MEDICAL ASSISTANCE
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2.b **Description of Services**: RURAL HEALTH CENTER SERVICES

Mandatory services/visits are provided in accordance with 42 CFR 440.230 per recipient. There are exceptions to visit limitations. Additional visits may be authorized if the visit is medically necessary.

Provider Types

Provider types may include: Physicians, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, Clinical Social Workers, Clinical Psychologists, RNs, and other ambulatory services otherwise approved in the State Plan.

Limitations

- Services not medically necessary;
- Investigational and experimental drugs and procedures;
- Cosmetic procedures, unless preauthorized;
- Separate reimbursement to a physician for services provided in a free-standing clinic in addition to the free-standing clinic reimbursement; and
- Payment for more than one visit to complete an EPSDT screening service.

STATE PLAN FOR MEDICAL ASSISTANCE
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STATE OF MARYLAND

2.c. **Description of Services:** FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Mandatory services/visits are provided in accordance with 42 CFR 440.230 per recipient. There are exceptions to visit limitations. Additional visits may be authorized if the visit is medically necessary.

Provider Types

Provider types may include: Physicians, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, Clinical Social Workers, Clinical Psychologists, RNs, and other ambulatory services otherwise approved in the State Plan.

Limitations

- Services not medically necessary;
- Investigational and experimental drugs and procedures;
- Cosmetic procedures, unless preauthorized;
- Separate reimbursement to a physician for services provided in a free-standing clinic in addition to the free-standing clinic reimbursement; and
- Payment for more than one visit to complete an EPSDT screening service

STATE PLAN FOR MEDICAL ASSISTANCE
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3.a **Description of Services**: X-RAY (RADIOLOGY) SERVICES

Services that utilize imaging to visualize areas within the human body.

Provider Types:

Free standing diagnostic radiology facilities that perform imaging services and meets the standards outlined in CFR §440.30.

Limitations:

Includes:

- Procedures are investigational or experimental in nature;
- Services included by the Program as part of the charge made by an inpatient facility, hospital outpatient department, freestanding clinic, or other Program-recognized entity;

3.b **Description of Services**: LABORATORY SERVICES

Laboratory Services provides for the examination of material derived from the human body, by means of one or more of the scientific disciplines for the purpose of obtaining scientific data that may be used to determine the presence, source, progress, or identity of disease agents and to aid in the prevention, diagnosis, treatment, and management of human disease.

Provider Types:

Medical laboratory means a CLIA certified and licensed facility operated for the examination of material derived from the human body, by means of one or more of the scientific disciplines.

Reference laboratory means a medical laboratory, which is enrolled with the Program as either a provider or a renderer, to which a medical laboratory provider refers specimens from Medical Assistance recipients for analysis.

Referring laboratory means a medical laboratory provider that refers specimens from Medical Assistance recipients for analysis.

Limitations:

The following are not covered:

- Procedures which are investigational or experimental in nature;
- Any service not medically necessary
- Services included by the Program as part of the charge made by an inpatient facility, hospital outpatient department, freestanding clinic, or other Program-recognized entity;
- Medical laboratory services for which there was insufficient quantity of specimen, improper specimen handling, or other circumstances that would render the results unreliable.

STATE PLAN FOR MEDICAL ASSISTANCE
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4a. Nursing facility services (other than in institutions for mental diseases)

- "Nursing facility services (other than in institutions for mental diseases)" means services provided to individuals who require (1) skilled nursing care and related services, (2) rehabilitation services, or (3) on a regular basis, health-related services above the level of room and board.

- Services are provided in facilities that fully meet the requirements for a State license to provide nursing facility services.

- Limitations. The following are not covered:

    - Services for recipients that are eligible for reimbursement under Title XVIII of the Social Security Act.

    - Services for which payment is made directly to a provider other than the nursing facility.

    - Bed reservations for leave of absence (to visit with friends or relatives or to participate in State approved therapeutic or rehabilitative programs) in excess of 18 days in any calendar year.

    - Bed reservations for acute hospitalization in excess for 15 days per hospital visit.

    - Administrative days not approved by the Department or its designee.

    - Audiology services.

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(Removed References to TB Facilities)