# Table of Contents

**State/Territory Name: Maryland**

**State Plan Amendment (SPA) #: 12-08**

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services (CMCS)**

Ms. Susan J. Tucker
Executive Director
Office of Health Services
Maryland Department of Health and Mental Hygiene
201 West Preston Street, 1st Floor
Baltimore, Maryland 21201

NOV 23 2012

RE: State Plan Amendment 12-08

Dear Mrs. Tucker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-08. This amendment modifies the methods and standards for making Medical Assistance payments to nursing facilities (NFs). Specifically, this SPA increases NF reimbursements by eliminating the net reduction factor applied to select cost centers used in developing rates, along with other modifies including establishing a new geographic rate location for Baltimore City facilities and replacing communicable disease care in the Heavy Duty Specialty level of care with intensive tracheotomy care.

We reviewed this amendment pursuant to sections 1902(a)(3), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Medicaid State plan amendment 12-08 effective July 1, 2012. We are enclosing the Form-179 and the amended plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerely,

Cindy Mann
Director, CMCS

90th = 12/19/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 12-08

2. STATE: Maryland

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN — AMENDMENT TO BE CONSIDERED AS NEW PLAN — X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $ 2,900
b. FFY 2013 $ 11,600

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D, pages 1, 2, 4-7, 7B, 11, 18, 19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D, page 1 (11-18), 2 (10-12), 4 (10-12), 5 (08-03), 6 (10-02), 7 (00-4), 7B (10-12), 11 (09-04), 18 (04-10), 19 (04-10)
**Delete:** Att 4.19D pp 20-21 (91-12) and 22-27(07-01)

10. SUBJECT OF AMENDMENT: This amendment is being submitted to reflect changes in State regulations related to reimbursement for nursing facility services.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: The Secretary of the Department of Health and Mental Hygiene

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Charles J. Milligan, Jr.

14. TITLE: Deputy Secretary, Health Care Financing, Department of Health and Mental Hygiene

15. DATE SUBMITTED: 9/20/2012

16. RETURN TO:
Susan J. Tucker
Executive Director
Office of Health Services
Department of Health & Mental Hygiene
201 W Preston St, 1st floor
Baltimore MD 21201

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: NOV 23 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2012

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

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 State fiscal periods beginning on or after July 1, 2009, rates are not revised using updated cost data.

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 4 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 1.5 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 4 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.

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 4 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 120 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.

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 1.5 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 1.5 percent, whichever is higher. For leased facilities, taxes and insurance costs are included whether paid by the lessor or the lessee.

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

Nursing Service Cost Center

Nursing Service rates are established for each of 4 levels of care (light, moderate, heavy and heavy special) and the following ancillary procedures: decubitus ulcer care, support surfaces for pressure ulcer care, central intravenous line, peripheral intravenous care, ventilator care, tube feeding, turning and positioning, oxygen/aerosol therapy, suction/tracheotomy, intensive tracheotomy care, and negative pressure wound therapy. Levels of care are based on a patient's dependency in the 5 activities of daily living (eating, continence, mobility, dressing, and bathing). The levels of care are defined as follows:

| | |
|---|---|
| Light Care | o Patient is dependent in 0-2 activities |
| Moderate Care | o Patient is dependent in 3-4 activities |
| Heavy Care | o Patient is dependent in all 5 activities |
| Heavy Special Care | o Patient is Heavy Care and requires one or more of the following ancillary procedures:<br>- decubitus ulcer care<br>- support surfaces for pressure ulcer care<br>- central intravenous line<br>- peripheral intravenous care<br>- ventilator care<br>- tube feeding<br>- negative pressure wound therapy<br>- intensive tracheotomy care |

Nursing rates are computed for 5 geographic regions as specified under COMAR 10.09.10.24C (which is appended to this attachment). Therefore 5 reimbursement rates are established for each level of care (ADL classification) and ancillary procedure. The precise method is as follows.

Each year every Maryland nursing home enrolled in the Program, unless specifically exempted due to low Medicaid occupancy, submits a wage survey which reports the wage rate(s) and associated hours for each nursing staff performing nursing services during a designated pay period. These staff are identified in 5 nursing staff occupation groups: Directors of Nursing, Registered Nurses, Licensed Practical Nurses, Nurse Aides and Certified Medication Aides.

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 |
| Central Intravenous Line | 1.04 |
| Peripheral Intravenous Care | 1.04 |
| Ventilator Care | 1.04 |

The nursing time rate for central intravenous line (not including the amount of the incentive factor) is multiplied by 0.5 to determine an adjustment amount to allow for the recruitment and special training of staff associated with this procedure. This amount is added to the nursing time rate as modified by the above incentive factor for central intravenous line.

The rate for ventilator care is the sum of the following:

(l) the nursing time rate multiplied by the above incentive factor for ventilator care

(2) the nursing time rate for ventilator care (not including the incentive factor adjustment) multiplied by 0.6 to establish an amount to allow for the recruitment and special training of staff, and the cost of supplies and equipment associated with this procedure;

(3) an amount for respiratory therapy determined from the mean hourly wage including fringe benefits for respiratory therapists in Maryland hospitals, from the Maryland Health Services Cost Review Commission Annual Wage Survey, multiplied by 3.75;

(4) the average per diem cost for a respirator support system is determined from the fee schedule for respirator equipment established in accordance with COMAR 10.09.27 Expanded EPSDT Referred Services; and

When an improvement in ADL classification is achieved by a facility for a resident who has been at the prior (higher) ADL classification for a minimum of 2 consecutive months, reimbursement for that resident will continue at the prior (higher) ADL classification until discharge, transfer, a return to the prior (higher) ADL classification, or for 2 subsequent months, whichever is less, in order to provide a transitional staffing adjustment to the facility in the amount of the difference between the reimbursement associated with the prior (higher) and the current (lower) ADL classifications.

The interim nursing service payment is subject to cost settlement. Providers with nursing costs less than reimbursement at standard per diem rates are allowed profit in the amount of 60 percent of the difference between their costs and the rate. Profit may not exceed 3 percent of the provider's maximum allowable reimbursement based upon standard per diem rates.

Nursing reimbursement in excess of costs and allowable profit is subject to recovery. Providers that are projected to spend less than their full reimbursement in this cost center, based on nursing costs reported in the most recent desk-reviewed cost report, indexed to the mid-point of the rate setting year, will have their interim rates reduced by 95 percent of the amount projected to be recovered. The balance of the recovery will occur at final cost settlement.

The above-mentioned percentage adjustment for central intravenous line is not subject to cost settlement.

A provider that renders care to Maryland Medicaid recipients of less than 1,000 days of care during the provider's fiscal year may choose to not be subject to cost reporting or field verification requirements and choose to accept as payment the projected Medicaid statewide average payment for each day of care. Any provider choosing this option is exempt from the subsequent nursing cost center wage survey.

(5) The allowance for movable equipment shall be:

(a) Established at $6,422 per licensed bed effective October 1,2007;

(b) Indexed forward as determined from §E of this regulation; and

(c) Added to the appraised value determined from §G(1), (2), (4), and (5) of this regulation.

(6) The allowance for movable equipment will exclude all items which:

(a) Are regularly replenished or stocked, consumed in their use or have a one-time use, or useful for a lifetime of less than 2 years; or

(b) Have an historical or aggregate historical cost of less than $500.

(7) The amount of the allowable mortgage debt as of the midpoint of the fiscal year shall be subtracted from the allowable appraised value from §G(2) of this regulation in order to establish the value of the net capital.

(8) The debt information to be used in §G(7) of this regulation shall be supplied to the Department or its designee by each facility in the form of a monthly amortization schedule within 60 days of the establishment of the debt.

(9) The value of net capital from §G(7) of this regulation shall be multiplied by 0.0857 (0.0757 for the period November 1, 2008 through June 30, 2013) except that, effective July 1, 2012, the value of the net capital for facilities located in Baltimore City shall be multiplied by 0.0942, in order to generate the net capital value rental.

COMAR 10.09.10.24

.24 Reimbursement Classes

A. The reimbursement classes for the Administrative and Routine cost center are as follows:

(1) Facilities in the Baltimore metropolitan region consisting of the following counties:

(a) Anne Arundel,
(b) Baltimore,
(c) Carroll,
(d) Harford, and
(e) Howard;

(2) Facilities in the Baltimore City;

(3) Facilities in the Washington region consisting of the following counties:

(a) Charles,
(b) Montgomery, and
(c) Prince George's;

(4) Facilities in the nonmetropolitan region consisting of the following counties:

(a) Allegany,
(b) Calvert,
(c) Caroline,
(d) Cecil,
(e) Dorchester,
(f) Frederick,
(g) Garrett,
(h) Kent,
(i) Queen Anne's,
(j) St. Mary's
(k) Somerset,
(l) Talbot,
(m) Washington,
(n) Wicomico, and
(o) Worcester.

B. The reimbursement classes for the Other Patient Care cost center are based on the county groupings as specified in §A of this regulation.

C. The reimbursement classes for the Nursing Service cost center are as follows:

(1) Facilities in the Baltimore region consisting of Baltimore City and Baltimore County;

(2) Facilities in the Central Maryland region consisting of the following counties:
(a) Anne Arundel,
(b) Carroll, and
(c) Howard;

(3) Facilities in the Washington region consisting of the following counties:
(a) Charles,
(b) Frederick,
(c) Montgomery, and
(d) Prince George's;

(4) Facilities in the nonmetropolitan region consisting of the following counties:
(a) Calvert,
(b) Caroline,
(c) Cecil,
(d) Dorchester,
(e) Harford,
(f) Kent,
(g) Queen Anne's,
(h) St. Mary's,
(i) Somerset,
(j) Talbot,
(k) Wicomico, and
(l) Worcester;

(5) Facilities in the Western Maryland region consisting of the following counties:
(a) Allegany,
(b) Garrett, and
(c) Washington.