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State Name: Maryland

State Plan Amendment (SPA)#: 15-0001

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Fifteen 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

Financial Management Group

APR 08 2015

Mr. Charles E. Lehman, Acting Deputy Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

RE: State Plan Amendment 15-0001

Dear Mr. Lehman:

We have completed our review of State Plan Amendment (SPA) 15-0001. This SPA modifies Attachment 4.19-D of Maryland's Title XIX State Plan. Specifically, the SPA adopts a prospective payment system for Maryland nursing facility services based on acuity adjusted resource utilization groups and reimburses capital costs through fair rental value.

We conducted our review of this SPA according to the statutory requirements at 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 state plan amendment 15-0001 effective January 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

/S/

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 15-0001

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
January 1, 2015

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

N/A

7. FEDERAL BUDGET IMPACT:
a. FFY 2015: $ 0
b. FFY 2016: $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

4.19D pp. 1, 1A(NEW), 1B (NEW), 1C (NEW), 1D (NEW), 1E (NEW), 2, 2A, 3, 3A (NEW), 4, 5, 7, 7A, and 7B.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

4.19D pp. 1, 2, 2A , 3, 4, 5, 7, 7A, and 7B.

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
☒ OTHER, AS SPECIFIED:
Susan J. Tucker, Executive Director
Office of Health Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/S/

13. TYPED NAME: Charles E. Lehman

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

15. DATE SUBMITTED:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: APR 08 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME: Kristin FAN

22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

4.19(d) Nursing facility payment rates, based on Maryland regulations COMAR 10.09.10, 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 percentages of two reimbursement methodologies, "cost settled" and "prospective." This combination of payments is referred to as the "blended rate." The State will phase out the cost settled reimbursement methodology on a schedule defined below. At the end of the phase out, payments to facilities shall be solely based on the prospective reimbursement methodology.

Rate Periods	Cost Settled Rate Percentage	Prospective Rate Percentage
January 2015 - June 2015	75%	25%
July 2015 - December 2015	50%	50%
January 2016 - June 2016	25%	75%
July 2016 - Ongoing	0%	100%

Under the cost settled reimbursement methodology, payment rates for nursing facilities are based on costs and are the sum of per diem reimbursement calculations in four cost centers: administrative/routine, other patient care, capital, and nursing service; and payment for therapy services. After payments are made, the State reviews each facility's Nursing Home Uniform Cost Report and settles the payment based on those costs. This reimbursement methodology's cost centers are labeled as "cost settled."

The State uses each facility's 2012 fiscal year end cost settled rate, indexed to account for budgeted rate increases through January 2015 and after, as the basis for the cost settled reimbursement methodology included in the blended rate.

Under the prospective reimbursement methodology, payment rates for nursing facilities are based on pricing and are the sum of per diem reimbursement calculations in four cost centers: administrative/routine, other patient care, capital, and nursing services (which include certain direct care costs such as therapies). This reimbursement methodology's cost centers are labeled as "prospective." Prospective payments, as well as the blended rate, are considered paid in full.

Additional allowable ancillary payments are listed and are paid prospectively and in full.

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.

Aggregate payments for these facilities may not exceed Medicare upper payment limits as specified at 42 CFR 447.272.

A provider that renders care to Maryland Medicaid recipients of less than 1,000 days of care during the provider's fiscal year may opt out of cost reporting requirements. To opt out, the provider must agree to accept as payment the average Medicaid payment for each day of care based on their geographic location as specified under COMAR 10.09.10.24A (which is appended to this attachment). Any provider choosing this option is exempt from the subsequent nursing cost center wage survey.

Nursing facilities that are owned and operated by the State are not paid in accordance with these provisions. These facilities 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 payment limits as specified at 42 CFR 447.272.

Unless otherwise defined, indexing noted under the Prospective Reimbursement Methodology refer to the latest Skilled Nursing Home without Capital Market Basket Index, published 2 months before the period for which rates are being calculated.

Prospective Reimbursement Methodology

The State initially establishes prices for each cost center for the rate period January 1, 2015, through June 30, 2015, and rebases prices between every two and four rate years. Prices may be rebased more frequently if the State determines that there is an error in the data or in the calculation that results in a substantial difference in payment, or if a significant change in provider behavior or costs has resulted in payment that is inequitable across providers. In years in which prices are not rebased, prices are subject to annual indexing.

Prospective Administrative/Routine Costs

The Administrative/Routine cost center includes the following expenses: administrative, medical records, 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).

The State establishes a price for each reimbursement group. The price is the median cost per diem of all facilities in the group multiplied by 1.025. The price is based on the most recent Nursing Home Uniform Cost Report submitted by each nursing facility, indexed by the market basket, divided by the greater of total resident days or days at full occupancy times an occupancy standard calculated as the statewide average occupancy, not including providers with occupancy waivers, plus 1.5 percent.

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

Prospective 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 10.09.10.24B (which is appended to this attachment).

The State establishes a price for each group. The price is the median cost per diem of all facilities in the group multiplied by 1.07. The price is based on the most recent indexed Nursing Home Uniform Cost Report submitted by each nursing facility divided by the total resident days.

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

Prospective Capital Costs

The Capital Cost center includes expenses for real estate taxes and the fair rental value of each facility.

At a minimum of every 4 years, each facility's building(s), nonmovable equipment and land are appraised. A fair rental value is calculated when the per bed cost appraisal, with a maximum of $110,000, is calculated and then multiplied by a geographic-specific amount (10 percent in Baltimore City, 8 percent in all other jurisdictions). The fair rental value is then divided by the greater of total resident days or days at full occupancy times an occupancy standard calculated as the statewide average occupancy, not including providers with occupancy waivers, plus 1.5 percent.

Two months prior to the start of a rate year, each facility's real estate taxes are divided by the greater of total resident days or days at full occupancy times an occupancy standard calculated as the statewide average occupancy, not including providers with occupancy waivers, plus 1.5 percent.

The per diem rate is the sum of the fair rental value and real estate tax calculations above.

Prospective Nursing Services Costs

The Nursing Services cost center includes costs related to the direct provision of nursing services to residents. Initially, the State sets a Nursing Services price for each of five groups based on geographic location as specified under COMAR 10.09.10.24C (which is appended to this attachment). The State sets the price based on the following steps:

(1) Each cost report's indexed Nursing Service costs is divided by the actual days of nursing care to arrive at the indexed Nursing Service cost per diem.
(2) The indexed Nursing Service cost per diem is normalized to the statewide average case mix index by multiplying the indexed Nursing Service cost per diem by the facility's normalization ratio calculated as the statewide average case mix index divided by the total facility case mix index.
(3) For each reimbursement group, each cost report's Medicaid resident days is used in the array of cost per diems in the previous step to calculate the Medicaid day weighted median.
(4) The final price for Nursing Service costs for each reimbursement group is calculated as the geographic regional Medicaid day weighted median Nursing Service cost multiplied by 1.0825.

The final Nursing Service rate for each nursing facility for each quarter is calculated as follows:

(5) Determine the Nursing Service price for the facility's geographic region;
(6) Calculate an initial nursing facility rate by multiplying the price by the facility average Medicaid case mix index divided by the statewide average case mix index;
(7) Calculate a Medicaid adjusted Nursing Service cost per diem by multiplying the per diem identified under step (1) by the Medicaid case mix adjustment ratio calculated as the facility average Medicaid case mix index divided by the total facility case mix index; and
(8) Calculate the final Nursing Service rate as the initial nursing facility rate reduced by any amount by which the Medicaid adjusted cost per diem is less than 95 percent of the initial nursing facility rate.

Facility-specific case mix is adjusted quarterly based on submitted, and reviewed, Minimum Data Set 3.0 from each facility. Case mix from the quarter before the immediate prior quarter is used to set the per diem for each rate quarter.

Facilities that are authorized to provide ventilator services utilize the above pricing methodology, however receive a payment for ventilator days of care using a facility average Medicaid case mix that includes only residents receiving ventilator care plus $280. The payment for ventilator services is prospective and paid in full. These are not subject to the blended rate phase-in.

Prospective Reimbursement of Allowable Ancillary Services

The payment for allowable ancillary services is prospective and paid in full. These are not subject to the blended rate phase-in. Prospective reimbursement for specialized support surfaces for pressure ulcer care is determined as follows:

(1) A Class A Support Surface is a mattress replacement which, has been approved as a Group 2 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Medical Equipment Regional Carrier. A Class A Support Surface will be reimbursed per day at the Medicare Durable Medical Equipment Regional Carrier Maryland monthly fee cap, in effect at the beginning of the State fiscal year, for HCPCS Code E0277 multiplied by 12 and then divided by the number of days in the State fiscal year.

(2) A Class B Support Surface is an air fluidized bed which has been approved as a Group 3 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Medical Equipment Regional Carrier. A Class B Support Surface will be reimbursed per day at the Medicare Durable Medical Equipment Regional Carrier Maryland monthly fee cap in effect at the beginning of the State fiscal year, for HCPCS Code EO194 multiplied by 12 and then divided by the number of days in the State fiscal year.

Bariatric beds and Power Wheel Chairs are covered under preauthorization by the State at a prospective rate with payment in accordance with Maryland regulations for medical supplies and equipment at COMAR 10.09.12.

Negative pressure wound therapy is reimbursed in accordance with rates established under COMAR 10.09.12, and includes the cost of pumps, dressings, and containers associated with this procedure.

Cost-Settled Administrative/Routine Costs

Reimbursement for these costs is based on each facility's 2012 fiscal year end cost settled rate.

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 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 (0.8 percent effective November 1, 2012 for rate periods for which the Statewide average occupancy is determined from data for periods prior to July 1, 2012), whichever is higher, for the calculation of ceilings.

The reimbursement rate 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 per diem rates for the Administrative/Routine cost center are 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 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 per diem payments in an amount up to 15 percent of the median per diem cost for dietary expense in its reimbursement group.

Cost-Settled Other Patient Care Costs

Reimbursement for these costs is based on each facility's 2012 fiscal year end cost settled rate.

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 10.09.10.24B (which is appended to this attachment). The 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.

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 per diem payments in an amount up to 15 percent of the median per diem cost for raw food expense in its reimbursement group.

Cost-Settled Therapy Services

These costs are not billable for dates of service on and after January 1, 2015. Payments for these costs are factored into each facility's 2012 fiscal year end cost settled rate that is used during the phase-in.

Reimbursement for therapy services will be determined as follows:

(1) Physical, occupational and speech therapy services will be reimbursed in 15 minute increments with a maximum per diem duration of 1 hour.

(2) Reimbursement rates shall be calculated as a percent of an hourly rate comprised of two components from the Medicare Therapy Services Guidelines and a per diem supply cost. The hourly rate shall be the sum of:

(a) The adjusted hourly salary equivalent amount for the type of therapy service effective for the period corresponding to the State fiscal year from the Medicare guidelines;
(b) One sixth of the total travel allowance for the period corresponding to the State fiscal year from the Medicare guidelines; and
(c) A supply allowance established at $0.30 for the period October 1, 1999 through June 30, 2000 and indexed in subsequent years based on the Consumer Price Index for All Urban Consumers (CPI-U), nonprescription medical equipment and supplies component from the U. S. Department of Labor Statistics, CPI Detailed Report, Table 4.

(3) Reimbursement rates shall be established at 25 percent of the hourly rate for a 15 minute therapy session, 50 percent of the hourly rate for a 30 minute therapy session, 75 percent of the hourly rate for a 45 minute therapy session and 100 percent of the hourly rate for a 60 minute therapy session.

(4) Providers shall be reimbursed based upon the Medicare Therapy Services Guidelines established for the geographic area in which the provider is located.

(5) Reimbursement for therapy services is not subject to cost settlement.

Cost-Settled Capital Costs

Reimbursement for these costs is based on each facility's 2012 fiscal year end cost settled rate.

Capital per diem payment is the sum of net capital value rental and the per diem for recurring costs including taxes, allowable interest, insurance and central office capital costs.

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 (0.8 percent effective November 1, 2012 for rate periods for which the Statewide average occupancy is determined from data for periods prior to July 1, 2012), 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 (0.8 percent effective November 1, 2012 for rate periods for which the Statewide average occupancy is determined from data for periods prior to July 1, 2012), whichever is higher. For leased facilities, taxes and insurance costs are included whether paid by the lessor or the lessee.

Cost-Settled Nursing Service Cost Center

Reimbursement for these costs is based on each facility's 2012 fiscal year end cost settled rate.

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

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.

Payment for nursing service is made at standard rates as determined above and are based on patient assessments undertaken in each facility by the Utilization Control Agent in order to ascertain the days of each type of procedure received by, and the ADL classification of each Medical Assistance resident.

Reserve for future use

Reserve for future use