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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 15-0018

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT # 021120164019

March 18, 2016

Shannon McMahon, Deputy Secretary
Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Ms. McMahon:

Enclosed is a copy of the approved State Plan Amendment (SPA), Transmittal Number 15-0018. This SPA updates Maryland's State Plan to reflect converting the community personal assistant services to an agency only model.

The effective date for this amendment is October 1, 2015. The CMS 179 form and the Approved State Plan pages are attached.

If you have questions about this SPA, please contact Lieutenant Commander Andrea Cunningham of my staff at 215-861-4325.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

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: 15-0018

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
October 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:
Att. 4.19B pg ~~64 (NEW)~~ 67 (NEW)
Att. 4.19A&B pg 12a, ~~13 & 13a~~ (DELETE)
Att. 3.1A pg 31B (AMEND) & Att. 4.19A&B pg 13, 13a (AMEND)
Att. 3.1A pgs 31B pg1 of 4 through 31C-1 (DELETE)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19A&B pg 12a, 13 & 13a
Att. 3.1A pgs 31B through 31C-1

10. SUBJECT OF AMENDMENT: To update community personal assistant services to convert to an agency only model and other administration changes. Additionally, to update reimbursement methodology that does not impact federal fiscal amount.

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: Shannon McMahon

14. TITLE: Deputy Secretary,
Office of Health Care Financing

15. DATE SUBMITTED: 12/28/15

16. RETURN TO:
Susan J. Tucker, Executive Director
OHS – DHMH
201 W. Preston St., 1st floor
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/28/15

18. DATE APPROVED: 3/18/2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
FRANCIS T. MCCULLOUGH

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR, DMCHO

23. REMARKS:

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

STATE OF MARYLAND

Services that require preauthorization
23. f. Personal Assistance services in a participant's home or community

Personal Assistance services are covered when preauthorized in a plan of service on an assessment of need. Personal Assistance Services also include:

1) Supports planning and
2) Nurse monitoring.

To participate in the Program, the personal assistance provider shall:

1) Comply with applicable federal and State laws, regulations, transmittals, and guidelines; and
2) Record time in accordance with procedures outlined in the Department's policies and procedures.
3) Be licensed as a residential services agency.

Supports planning services coordinate services and develop the plan of service. To participate in the Program as a supports planning provider, a provider shall be:

1) Identified by the Department through a solicitation process and agree to be monitored by the Department; or
2) The area agency on aging.

Nurse monitoring services provided by a registered nurse who completes nursing assessments on participants and evaluates the delivery of personal assistance services. To participate in the program as a provider of nurse monitoring, a provider shall be enrolled with Community First Choice.

LIMITATIONS

The following services are not covered:

1) Skilled nursing;
2) Services primarily for the purpose of housekeeping;
3) Meals delivered to the home;
4) Expenses incurred by providers while escorting participants to obtain medical diagnosis or treatment; and
5) Travel time;
6) Nurse monitoring services in the absence of personal assistance service.

DELETE

Feild, Rosemary A. (CMS/NC)

From: Brown, Sharon J. (CMS/CMSO)
Sent: Thursday, January 15, 2009 5:01 PM
To: Feild, Rosemary A. (CMS/NC); Corbin, Angela T. (CMS/CMSO); Wallace, Judi (CMS/CMSO); Mccullough, Francis T. (CMS/NC)
Cc: Silanskis, Jeremy D. (CMS/CMSO); DOBSON, CAMILLE (CMS/CMSO); Whitaker, Carolyn M. (CMS/NC); Freeze, Janet G. (CMS/CMSO); EARHART, DEBRA D. (CMS/NC); Robison, Daniel P. (CMS/NC); DOBSON, CAMILLE (CMS/CMSO)
Subject: 12/20/94 SMDL
Attachments: 12201994smdl.pdf

Attached is the aforementioned 12/20/94 SMDL on admin case management, FYI.

Thanks!

Sharon Brown | Administrative Claiming Team, Division of Reimbursement and State Financing | Financial Management Group | Centers for Medicare & Medicaid Services | ☎: 410-786-0673 | ✉: sharon.brown@cms.hhs.gov

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From: Brown, Sharon J. (CMS/CMSO)
Sent: Thu 1/15/2009 5:00 PM
To: Feild, Rosemary A. (CMS/NC); Corbin, Angela T. (CMS/CMSO); Wallace, Judi (CMS/CMSO); Mccullough, Francis T. (CMS/NC)
Cc: Silanskis, Jeremy D. (CMS/CMSO); DOBSON, CAMILLE (CMS/CMSO); Whitaker, Carolyn M. (CMS/NC); Freeze, Janet G. (CMS/CMSO); EARHART, DEBRA D. (CMS/NC); Robison, Daniel P. (CMS/NC); DOBSON, CAMILLE (CMS/CMSO)
Subject: RE: RE MD SPA 08-11 State Of Maryland State Plan Personal Care Program - Case Monitoring

Rosemary, et al:

In reviewing the nurse care monitoring activities submitted by Maryland, it's important to remember that administrative case management is not a separate Medicaid claiming category defined in statute or regulation.

Section 4302 of the State Medicaid Manual (SMM) and the 12/20/94 State Medicaid Director Letter (SMDL) on administrative case management (ACM) state that the following activities may be properly claimed as ACM (although this list was not intended to be all-inclusive):

- Medicaid eligibility determinations and re-determinations
- Medicaid intake processing
- Medicaid preadmission screening for inpatient care
- Prior authorization for Medicaid services
- Utilization review
- Outreach activities

It's difficult to directly link some of the activities described by Maryland (below) to those listed above. Then again, if one were to creatively interpret the SMM and SMDL guidance, anything short of a direct medical service could be considered ACM.

Perhaps a better standard against which to compare Maryland's activities are the principles for administrative claiming listed on the 1994 SMDL (attached):

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01/22/2009 Supersedes: 05-09

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- An allowable administrative cost must be directly related to a Medicaid State plan or waiver service.
- An allowable administrative cost cannot reflect the cost of providing a direct medical or remedial service.
- An allowable administrative cost cannot be an integral part or extension of a direct medical or remedial service, such a patient follow-up, assessment, patient education, counseling, or other physician "extender" activities.
- An allowable administrative cost may not include funding for a portion of general public health initiatives that are made available to all persons.
- An allowable administrative cost may not include the overhead costs of operating a provider facility.
- An allowable administrative cost may not include the operating costs of an agency whose primary purpose is other than operation of the Medicaid program.
- An allowable administrative cost must be included in a Cost Allocation Plan that is approved by DCA and supported by a system that has the capability to isolate the costs that are directly related to the support of the Medicaid program from all other costs incurred by the agency.

Having said all that, my biggest concern about Maryland's description are the home visits and development of a personal care plan. Both of those appear indicative of case management services, not administration.

But I think it's important for everyone to weigh in here, not just the so-called administrative claiming experts, so I'll be interested to hear what others think of Maryland's prospects for submitting a CAP amendment to claim the costs of these activities and removing them from the pending SPA.

Thanks!

Sharon Brown | Administrative Claiming Team, Division of Reimbursement and State Financing | Financial Management Group | Centers for Medicare & Medicaid Services | ☎: 410-786-0673 | ✉: sharon.brown@cms.hhs.gov

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From: Feild, Rosemary A. (CMS/NC)
Sent: Thu 1/15/2009 4:36 PM
To: Corbin, Angela T. (CMS/CMSO); Brown, Sharon J. (CMS/CMSO); Wallace, Judi (CMS/CMSO); Mccullough, Francis T. (CMS/NC)
Cc: Silanskis, Jeremy D. (CMS/CMSO); DOBSON, CAMILLE (CMS/CMSO); Whitaker, Carolyn M. (CMS/NC); Freeze, Janet G. (CMS/CMSO); EARHART, DEBRA D. (CMS/NC); Robison, Daniel P. (CMS/NC)
Subject: FW: RE MD SPA 08-11 State Of Maryland State Plan Personal Care Program - Case Monitoring

Maryland Medicaid submitted the description below for its nurse case monitoring associated with personal care services (SPA 08-11). We had asked for this description on Tuesday's call to provide T/A on a cost allocation plan, which we had suggested as being more appropriate than inclusion in the State plan, based on the info at hand. We want to be very clear that these are administrative activities before the State develops a cost allocation plan (CAP) amendment for these costs. If this description includes services that belong in the State plan, the CAP is moot, and the State will have to resolve the language at 4.19A&B, page 13. (MD has said it would probably withdraw this SPA to remove medical day care.)

Please review the following and let us know what you think. If you want me to set up a call to discuss this further, please let me know. Thanks!

Rosemary Feild
Medicaid and SCHIP Representative for Maryland
CMS Region III
The Public Ledger Bldg., Suite 230
150 S. Independence Mall West
Philadelphia, PA 19106-3499
(215) 861-4278
FAX (215) 861-4280
rosemary.feild@cms.hhs.gov

From: Marc Blowe [mailto:BloweM@dhmh.state.md.us]

TN: 15-0018 Approval Date: MAR 18 2016

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Admin

6325 Security Boulevard
Baltimore MD 21207

DEC 20 1994

Dear State Medicaid Director:

As the result of a recent examination of claims for administrative match which included some inappropriately claimed activities, we believe it is important to reiterate our long-standing policy on allowable administrative costs. Moreover, because the situation prompting this examination included activities identified as administrative case management (ACM), as well as other administrative functions performed by State and local governments, we would like to amplify our policy with specific reference to such situations.

Section 1903(a) of the Social Security Act directs payment of Federal financial participation (FFP), at different matching rates, for amounts "found necessary by the Secretary for the proper and efficient administration of the State plan." The Secretary, rather than the State, is the final arbiter of which activities fall under this definition. We have consistently held that allowable claims under this authority must be directly related to the administration of the Medicaid program. Thus, activities directed toward services not included under the Medicaid program, although such services may be valuable to Medicaid beneficiaries, are not necessary for the administration of the Medicaid program, and therefore are not allowable administrative costs. In addition, with regard to any allowable administrative claim, payment may only be made for the percentage of time spent which is actually attributable to Medicaid eligible individuals.

The Health Care Financing Administration (HCFA) has approved cost allocation plans from States which include the following types of administrative costs necessary for the proper and efficient administration of the State plan (Note: this list is not all-inclusive):

- Medicaid eligibility determinations;
- Medicaid outreach;
- Prior authorization for Medicaid services;
- Medicaid Management Information System development and operation;

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- Early and Periodic Screening, Diagnostic, and Treatment administration.
- Third Party Liability activities; and
- Utilization review.

In 1986, Congress recognized case management as a separate service eligible for matching at the Federal Medical Assistance Percentage (FMAP), when such services were provided to a targeted group of high risk individuals and the State submitted an amendment to its Medicaid State plan. As Medicaid agencies expanded their use of individual case management activities, both for targeted case management and for the general Medicaid population, they asked whether some of the case management activities which were not claimable as targeted case management were instead claimable as administrative costs. In Section 4302 of the State Medicaid Manual (SMM), HCFA identifies the following case management activities which may be properly claimed as ACM (but not as targeted case management):

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services;
- Utilization review; and
- Outreach activities to inform or persuade beneficiaries or potential beneficiaries to enter into care through the Medicaid system.

(NOTE: This group of services which States may identify as ACM was not intended to be all-inclusive.)

This SMM section did not authorize a new category for administrative claiming but only recognized that existing types of coverable administrative costs could be understood as falling under the general concept of case management. For example, the costs for time spent by a State employee who worked specifically on conducting a prior authorization review for a Medicaid service could be claimed as an administrative

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cost even though this activity may be referred to as ACM by the State. In our view, such services could have always been claimed as administrative costs because of their direct connection to the proper and efficient administration of the Medicaid State plan. While some case management activities may fall within the scope of both administrative and targeted case management, a State may not claim the same costs both as targeted case management and ACM at the same time.

Medicaid Policy

Given the results of our examination of claims for administrative match and based on recent inquiries from States and comments received from the publication of the Notice of Proposed Rulemaking (NPRM) on targeted case management, we believe that the general principles governing Medicaid reimbursement of administrative costs and particularly ACM, as set out in the SMM and in the NPRM on targeted case management, require additional amplification. By addressing the application of this policy in several particular situations we hope that States will better understand which costs may be identified and claimed as administrative costs under the Medicaid program.

As cited earlier, the overarching policy guiding such decisions is that the costs must be "found necessary by the Secretary for the proper and efficient administration of the State plan." (Emphasis added.) HCFA exercises the Secretary's authority to determine what is necessary and proper for the efficient administration of the State plan.

The following principles reflect determinations made by HCFA in applying this policy. States should follow these principles in evaluating the legitimacy of their claims for administrative match. An allowable administrative cost:

- must be directly related to Medicaid State plan or waiver services. Allowable administrative costs do not include gaining access to or coordinating non-Medicaid services even if such services are health-related. Also, allowable administrative costs do not include gaining access to or coordinating social, educational, vocational, legal, or other non-Medicaid services. The cost of gaining access to or coordinating non-Medicaid services may be claimable as targeted case management if applicable State plan requirements are met.

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- cannot reflect the cost of providing a direct medical or remedial service, such as immunizations or psychological counseling.

- cannot be an integral part or extension of a direct medical or remedial service, such as patient follow-up, patient assessment, patient education, counseling (including pharmacy counseling), or other physician extender activities. Such services are properly paid for as part of the payment made for the medical or remedial service. Because Medicaid providers have agreed to accept service payment as payment in full, such providers may not claim an additional cost as administrative cost under the State plan.

- may not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, unless the campaign is explicitly directed at assisting Medicaid eligible individuals to access the Medicaid program.

- may not include the overhead costs of operating a provider facility, such as the supervision and training of providers.

- may not include the operating costs of an agency whose purpose is other than the administration of the Medicaid program, such as the operation of a probation department.

  However, to the degree that a governmental agency directs some fraction of its efforts <u>exclusively</u> to Medicaid claimable administrative services, <u>and can accurately identify that fraction</u>, it may claim an appropriate portion of its operating costs to support that function if all other criteria for administrative claiming is satisfied (e.g., direct relationship to the State plan, health-related, etc.).

- must be included in a cost allocation plan that is approved by HCFA and supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the agency.

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- must, if claimed at the enhanced matching rate for activities rendered by skilled professional medical personnel (SPMP), include only administrative activities performed by the SPMP which require the level of medical expertise of such SPMP in order to be performed effectively and meet all requirements of Federal regulations at 42 CFR 432.50(d).

- cannot be incurred with regard to any services provided to individuals who are "inmates of a public institution" as this exclusion is specified in regulations and interpreted by HCFA. This would include juveniles as well as adults detained temporarily in locked public facilities awaiting disposition. (Individuals whose disposition has already been determined, but who are housed temporarily in such facility until placement to other than inmate status elsewhere is available, are not considered inmates.)

Prior to implementation of State or local systems for claiming administrative costs, States should ensure that their methodologies for distinguishing administrative activities eligible for FFP conform to the guidelines outlined above and are included in the State's cost allocation plan submitted to and approved by the Director of the Division of Cost Allocation (after consultation with HCFA) in accordance to Federal regulations at 45 CFR, Subpart E. Many case management activities which are not allowable under these guidelines may be allowable as targeted case management services, through an approved amendment to the State plan. Guidelines for targeted case management may be found in the SMM, Section 4302.

Furthermore, States should ensure that State and local agency time coding systems used to determine Medicaid utilization are designed to distinguish allowable administrative costs from non-allowable expenses. These time coding systems must also be approved by HCFA prior to State and local implementation and must meet the simplicity of administration requirements of the Social Security Act.

We plan to issue an expanded list of policy interpretations to guide States' decision making regarding allowable costs for Medicaid administrative match for ACM and other functions performed by State or local governments in a SMM issuance. We also intend to incorporate these interpretations in regulations.

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Superceded TN: 05-09

Effective date: October 1, 2015

State Medicaid Director

e States find this material helpful and would welcome
input on areas in which you believe further policy
.rpretation would be useful.

Sincerely yours,

[redacted]

Sally K. Richardson
Director
Medicaid Bureau

cc:
All Regional Offices

Ms. Lee Partridge
Director, Health Policy Unit
American Public Welfare Association
Suite 500
810 First Street, NE
Washington, D.C. 20002-4205

Mr. Carl Volpe
Senior Policy Analyst
Human Resources Group
National Governors' Association
Suite 250
444 North Capitol Street, NW
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Ms Joy Wilson
Director, Health Committee
National Conference of State Legislatures
Suite 500
444 North Capitol Street, NW
Washington, D.C. 20001

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n. Hearing Aid Services – Hearing aids and accessories are reimbursed at the provider's acquisition cost which is defined as the actual cost of a product to a provider. For repair materials, the maximum reimbursement is acquisition cost. All professional services are reimbursed according to the fee schedule or the provider's usual and customary charge, whichever is less.

o. Oxygen and Related Respiratory Equipment.

[1] For covered services at the lower of:

[a] The provider's customary charge to the general public;

[b] The Department's fee schedule

[2] For repairs to purchased respiratory equipment in accordance with the following:

[a] Actual cost to the provider for all materials; and

[b] Reasonable charges for labor, not to exceed the usual and customary charges for similar services in the provider's area; or

[c] Actual charges for repairs done by other than the provider as evidence by an invoice attached to the bill.

p. Free-standing dialysis facilities services – reimbursed for dialysis services in accordance with the provisions of Title XVIII regulations.

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

STATE OF MARYLAND

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

STATE OF MARYLAND

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Maryland

Community Personal Assistance Services 4.19B
State Plan Option Reimbursement

1) Effective October 1, 2015, payments for community personal assistance services as defined per Attachment 3.1A page 31B shall be reimbursed in 15-minute units. Both government and non-government providers of community personal assistance services are reimbursed pursuant to the same fee schedule. The fee schedule is effective for services provided on or after October 1, 2015 and are published on the Department's website at: https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Community%20First%20Choice.aspx.

2) Payment limitations:
   - The provider may not bill the Department or the recipient for:
     - o Missed or broken appointments; and
     - o Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.