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State Name: Maryland

State Plan Amendment (SPA)#: 18-0010

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Sixteen (16) SPA Pages

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

Mr. Dennis Schrader, Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

RE: State Plan Amendment 18-0010

October 24, 2018

Dear Mr. Schrader:

We have completed our review of State Plan Amendment (SPA) 18-0010. This SPA modifies Attachment 4.19-D of Maryland's Title XIX State Plan. Specifically, the SPA increases nursing facility rates for SFY 2018, by adjusting reduction factors applied to certain cost centers, increases the ventilator add-on and the capital cost ceiling, and removes obsolete cost reimbursement language.

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 18-0010 effective July 1, 2018. 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/

Kristin Fan
Director

Enclosures

cc: Nelly Evans
Mark A. Leeds
Molly Mara
Nina McHugh
Susan Panek
Eric Saber

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: 18-0010	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 1st, 2018	

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 2018: $5,394 b. FFY 2019: $16,183
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19D pages 1, 1A, 1B, 1C, 1D, 2, 3,4, 5, 6,7 (AMEND) Attachment 4.19D pages 1E, 2A, 3A, 7A, 7D (DELETE)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19D pages 1 (15-0015) Attachment 4.19D pages 1A (17-0008) Attachment 4.19D pages 1B, 1C, 1D, 1E, 2, 2A, 3, 3A, 4, 5, 7, 7A, 7B (15-0001) Attachment 4.19D pages 6 (12-08)

10. SUBJECT OF AMENDMENT: 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: Mark A. Leeds, Director Long Term Services & Supports Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/	16. RETURN TO: Mark A. Leeds, Director Long Term Services & Supports Admin. Office of Health Services — MDH 201 W. Preston St., 1st floor Baltimore, MD 21201
13. TYPED NAME: Dennis Schrader	
14. TITLE: Medicaid Director Maryland Department of Health	
15. DATE SUBMITTED: September 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: OCT 24 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2018	20. SIGNATURE OF REGIONAL OFFICIAL: /S/
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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4.19(d) Nursing facility payment rates, based on Code of 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 based on a 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). Prospective payments 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 choose to not be subject to cost reporting requirements and to accept as payment the Medicaid statewide average payment for each day of care. 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.

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.

During the period July 1, 2018 through June 30, 2019, provider payment rates shall be reduced by 2.387 percent from the methodology described herein.

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Prospective Reimbursement Methodology

The State initially established 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.

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 10.09.10.30.

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.

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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 10.09.10.30.

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.

Capital Costs

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

At least 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 $120,000, 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.

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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 10.09.10.30. 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 $285. The payment for ventilator services is prospective and paid in full.

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Reimbursement of Allowable Ancillary Services

The payment for allowable ancillary services is prospective and paid in full. 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.

Power wheelchairs 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.

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

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