Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 10 Nursing Facility Services

Authority: Health-General Article, §§2-104(b), 15-103, 15-105, 19-14B-01, and 19-310.1, Annotated Code of Maryland

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Accrual basis" means recording revenue in the period when earned, regardless of when collected, and recording expenses in the period when incurred, regardless of when paid.

(2) "Administrative day" means a day of care rendered to a recipient who no longer requires the level of care being provided.

(3) "Allowable cost" means costs that are includable in the per diem rate and that represent the provider's actual cost as verified by the Department or the Department's designee.

(4) "Appropriate facility" means a facility located within a 25-mile radius of the location of the facility currently rendering care to the recipient or a more distant facility if acceptable to the recipient, which facility is licensed and certified to render the recipient's required level of care.

(5) "Bad debts" means amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services which, when made or entered, were considered collectible in money in the relatively near future.

(6) "Case mix index (CMI)" means a numeric score that identifies the average relative nursing resource needs for the residents classified under the Resource Utilization Group (RUG) based on the assessed nursing needs of the resident, whose values are set forth as CMI Set F01, located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.

(7) "Centers for Medicare and Medicaid Services (CMS)" means the federal agency that is located in the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

(8) "Change of ownership" means:

(a) One of the following occurs:

(i) The merger of the provider into the acquiring entity and the acquiring entity's tax identification number remains;

(ii) The assignment, transfer, disposition, lease, or sale of all or substantially all of a provider's assets to another entity;

(iii) The consolidation of two or more providers, resulting in the creation of a new entity; or

(iv) The merger of the provider into another entity, or the consolidation of two or more entities, resulting in the creation of a new entity;

(b) A provider's Medical Assistance participating provider number dissolves or will no longer be utilized for purposes of billing the Program for covered services; and

(c) A new Medical Assistance participating provider number or tax identification number is used instead.

(9) "Cost center" means one of the groups into which similar categories of costs are assigned for reimbursement rate determination: Administrative and Routine, Other Patient Care, Nursing Service, and Capital.

(10) "Cost report period case mix index" means the simple average of the day weighted facility case mix indices for residents of all payer sources from the final quarterly resident rosters for a nursing facility, carried to four decimal places, for the quarterly resident roster periods that most closely match a cost reporting period.

(11) "Credit balance" means:

(a) A third party payment, which is in addition to the Medicaid payment;

(b) The Medicaid payment in excess of the amount due the provider; or

(c) A duplicate payment.

(12) "Department" means the Maryland Department of Health, which is the single State agency designated to administer the Maryland Medical Assistance Program pursuant to Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

(13) "Facility" means a facility licensed under COMAR 10.07.02 and certified as meeting the requirements of Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., for participation as a nursing facility.

(14) "Facility average Medicaid case mix index" means the day-weighted average case mix index for all identified Medicaid days from each nursing facility's final resident roster for each resident roster quarter calculated as the sum of the number of days each assessment associated with a Medicaid payer source is active times the assessment CMI divided by the sum of all Medicaid payer source days.

(15) "Final report" means the third party liability audit report issued to a provider stating the total amount due to the Department as a result of the completed audit.

(16) "Fiscal year" means a 12-month reporting period covering the same period as the facility's tax return, unless waived by the Department according to standards found in Medicare Provider Reimbursement Manual, HCFA Publication 15-1.

(17) "Indemnity bond" means a bond posted by the provider to ensure that the provider is able to fulfill any financial obligations to the Department upon sale of the facility.

(18) "Interim Working Capital Fund" means funding made available to providers on a temporary basis that shall be repaid to the Department.

(19) "Market basket index" means inflation indices from the latest Skilled Nursing Home without Capital Market Basket Index, published 2 months before the period in which rates are being calculated and which is available from CMS at www.cms.gov, or a comparable index available from, and used by, CMS, if this index ceases to be published by Global Insight, Inc. or its successor.

(20) "Maryland Health Care Commission" means the agency established by Health-General Article, Title 19, Subtitle 1, Annotated Code of Maryland.

(21) "Medicaid" means Medical Assistance provided under the State Plan approved under Title XIX of the Social Security Act.

(22) "Medical Assistance Program" means a program of comprehensive medical and other health-related care for indigent and medically indigent persons.

(23) "Medicare upper payment limit" means that aggregate payments to nursing facilities may not exceed the limits established for such payment in 42 CFR §447.272.

(24) "Minimum Data Set (MDS)" means the MDS required by 42 CFR §483.20 and set forth in the Resident Assessment Instrument published by CMS, and available at www.cms.gov, incorporated herein by reference, as amended and supplemented, a core set of screening, clinical, and functional status elements, including common definitions and coding categories that forms the foundation of the assessment required for all residents in Medicare-certified or Medicaid-certified nursing facilities.

(25) "New facility" means:

(a) A facility that has not been a provider during the previous 12-month period or, for rates effective January 1, 2015 and after, does not have a cost report in the price database as set forth in Regulation .09B(1) of this chapter; and

(b) A facility not defined as a replacement facility.

(26) "Noncompliant" means:

(a) A provider fails to submit to the Department the required quarterly report of credit balances;

(b) A provider fails to submit a quarterly report which provides sufficient data relating to the credit balances it maintained during that quarter; or

(c) A random audit by the Department reveals errors or omissions in a provider's credit balance report.

(27) Nursing Facility (NF).

(a) "Nursing facility" means an institution which is primarily engaged in providing to residents:

(i) Skilled nursing care and related services for residents who require medical or nursing care;

(ii) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

(iii) On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

(b) "Nursing facility" means an institution which is licensed by the Department under COMAR 10.07.02.

(c) "Nursing facility" does not include an institution which is primarily for the care and treatment of mental diseases, an intellectually disability or a developmental disability.

(28) "Nursing facility services" means services provided to individuals who do not require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities.

(29) "Owner" means a party or entity having any ownership interest in the facility.

(30) "Patient day" means care of one patient for 1 day of service. The day of admission is counted as 1 day of care, but the day of discharge is not counted. If a patient is discharged on his day of admission, 1 patient day will be counted.

(31) "Payroll-Based Journal" means a system for facilities to submit staffing information to meet the requirements of §6106 of the Affordable Care Act (ACA) that requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data.

(32) "Personal needs fund" means that portion of the recipient's resource retained by the recipient for his personal use.

(33) "Predischarge plan" means:

(a) A written document describing who has operational responsibility for discharge planning;

(b) The manner in and methods by which that person will function;

(c) The time period in which each recipient's need for discharge planning will be determined;

(d) The maximum time period after which a reevaluation of each recipient's discharge plan will be made;

(e) The local resources available to the provider, the individual, and the attending physician to assist in developing and implementing individual discharge plans; and

(f) Provisions for periodic review and reevaluation of the provider's discharge planning program.

(34) "Program" means the Medical Assistance Program.

(35) "Prospective rate" means a facility-specific quarterly per diem rate based on the RUG classification system, and calculated as the sum of:

(a) Administrative and Routine rate as calculated in accordance with Regulation .09 of this chapter;

(b) Other Patient Care Rate as calculated in accordance with Regulation .10 of this chapter;

(c) Capital Rate as calculated in accordance with Regulation .11 of this chapter; and

(d) Nursing Rate as calculated in accordance with Regulation .12 of this chapter.

(36) "Provider" means a facility which has in effect a provider agreement with the Department.

(37) "Provider agreement" means the contract between the Department and the provider covering the obligations of the parties under the Medical Assistance Program.

(38) "Purchaser" means an entity that participates in a change of ownership with a provider by:

(a) Having a provider merge into the entity;

(b) Accepting the assignment, transfer, disposition, or sale of all or substantially all of a provider's assets; or

(c) Being a new entity that results from the consolidation of the provider with a third party.

(39) "Quality measure" means a specific performance criterion, as described in Regulation .15 of this chapter, used to assess a facility's performance level.

(40) "Random sample" means the selection for audit by the Department of representative share of the providers complying with the requirement of submitting a quarterly report of credit balances to the Department.

(41) "Recipient" means a person who is certified as eligible for, and is receiving, Medical Assistance benefits.

(42) "Recreational services" means those organized activities provided for the enjoyment of the patients that are designed to promote their physical, social, and mental well-being.

(43) "Reimbursement class" means the group of providers for which a separate per diem rate will be prepared in the Administrative and Routine, Other Patient Care, and Nursing Service cost centers based on geographic region as set forth in Regulation .30 of this chapter.

(44) "Relative of the owner" means the owner's husband, wife, natural parent, natural child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild.

(45) "Replacement facility" means:

(a) A newly constructed nursing facility that replaces an existing licensed and certified facility; or

(b) A facility that was closed for significant renovation that reopens and is approved by the Department as a replacement facility.

(46) "Resident roster" means a list of all residents in a nursing facility for a calendar quarter based on MDS assessments and tracking forms, accurately and successfully transmitted by the nursing facility into the CMS-approved submission system, used for the calculated day-weighted case mix indices for Medicaid, Medicare, and other payment sources.

(47) "Resource" means that portion of a recipient's income available toward the cost of medical and remedial care as determined by the Department or its designee.

(48) "Resource Utilization Group (RUG)" means the version IV (RUG-IV), 48-Group classification system, that has been developed by CMS for grouping nursing facility residents according to the residents' functional status and anticipated uses of services and resources as identified from data supplied by the MDS.

(49) "Secretary" means the Secretary of Health.

(50) "Special focus facility" means a facility identified by the Centers for Medicare and Medicaid Services as having:

(a) More problems than other nursing homes;

(b) More serious problems than other nursing homes; and

(c) A pattern of serious problems that has persisted over a long period of time.

(51) "Specialized rehabilitative therapy services" means those services furnished by a provider as an integral part of a patient's care plan ordered by a physician and provided in conjunction with continuous nursing care for the purpose of the restoration of normal form and function after injury or illness. The services shall be performed by a licensed physical therapist, licensed physical therapy assistant, or registered occupational therapist.

(52) "Standby letter of credit" means a written instrument prepared by a provider's bank authorizing the Department to draw on the bank, upon sale of the facility.

(53) "Statewide average case mix index" means the simple average of all of the cost report period case mix indices for the rate year.

(54) "Statewide average Medicaid case mix index" means the Medicaid day weighted average of all nursing facilities' case mix indices for the Medicaid days identified on the final resident rosters for each resident roster quarter.

(55) "Substandard quality of care" means a finding of substandard care in accordance with 42 CFR §488.301.

(56) "Third party" means any individual entity or program that is or may be liable to pay all or part of the medical cost of any medical assistance furnished to a recipient under the Medical Assistance Program, including private health insurance, employment related health insurance, medical support from absent parents, automobile insurance, court judgments or settlements from a liability insurer, state workers' compensation, first party probate-estate recoveries, or any federal programs.

(57) "Third party liability audit" means a financial review of Medical Assistance payments to a provider to ascertain the legal liability of third parties to pay for care and services available under the Medical Assistance Program.

(58) "Third party liability review" means a financial review of the credit balances of a nursing facility to ascertain the legal liability of third parties to pay for care and services available under the Medical Assistance Program.

(59) "Uniform cost report" means the cost report format which each facility is required to use in the submission of its fiscal year cost and utilization data, including supplemental schedules and other balance sheet and administrative data.

.02 License Requirements.

In order to participate in the Program, a provider shall be licensed by the Department, pursuant to Health-General Article, §19-301 et seq., Annotated Code of Maryland, and COMAR 10.07.02, and shall obtain other licenses, as may be required by applicable State and local laws.

.03 Conditions for Participation.

To participate in the Program, the provider shall:

A. Be certified by the Department at its total licensed nursing facility bed capacity as meeting the requirements of Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., for participation as a nursing facility;

B. Be in compliance with preadmission screening and resident review requirements as described by 42 CFR Part 483, Subpart C (1996);

C. Be in compliance with the requirements of COMAR 10.09.36;

D. Be approved for participation by the Department;

E. Have a provider agreement in effect;

F. Employ an organized medical staff or a medical director who is a licensed physician;

G. Provide, according to the needs of the recipient, those services listed in Regulation .04 of this chapter;

H. Accept payment by the Department as payment in full for covered services rendered and make no additional charge to any person for covered services except as provided for in Regulation .28 of this chapter;

I. Maintain adequate records for a minimum of 6 years and make them available, upon request, to the Department or its designee;

J. Provide services without regard to race, color, age, sex, national origin, marital status, physical or mental handicap;

K. Verify the recipient's eligibility;

L. Place no restriction on a recipient's right to select providers of his choice;

M. Have in effect a predischarge plan;

N. Agree that if the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or preauthorized in accordance with Regulation .06 of this chapter, the provider may not seek payment for that service from the recipient;

O. Perform utilization control functions for all recipients designated eligible for nursing facility services as described by 42 CFR §§346.370, 456.360, 456.371, 456.380, and 456.381 (1996), and as required by the Utilization Control Plan for Selected Institutional Services Reimbursed by the Maryland Medical Assistance Program;

P. Notify the Department or its designee of patient activity or circumstance that affects placement, eligibility, or reimbursement on such form and at such time as specified by the Department;

Q. Before discharging any Medical Assistance recipient certified as requiring nursing facility services, place in the recipient's permanent medical record the following information on a consent form designated by the Department, a copy of which shall be submitted to the Department and to the Office on Aging:

(1) A certification that the recipient or guardian has:

(a) Been informed of the recipient's right to remain in the discharging facility and have the cost of care paid by the Medical Assistance Program;

(b) Been informed that the Medical Assistance Program will not pay for room and board in a setting outside of a nursing facility and that the Program may pay for the cost of medical services received outside of a nursing facility subject to medical and financial eligibility determinations and covered services limitations;

(c) Been informed of the recipient's right as a patient, as stated in the Health-General Article, §19-345, Annotated Code of Maryland;

(d) Been informed of the services provided by and the location of the alternative placement;

(e) Voluntarily given informed consent to the transfer;

(2) If the recipient or guardian is unable or unwilling to sign the consent form, submit to the Department a written explanation of the reason written consent was not obtained, a copy of which shall be placed in the recipient's medical record;

R. Agree that if the Program denies payment due to late billing, the provider may not seek payment from the recipient;

S. Include in all contracts with a cost or value over a 12-month period of $10,000 or more, with any subcontractor, a clause allowing the Department or its agent access to the subcontractor's books, documents, and records which are necessary to verify the nature and extent of costs of the services furnished under the contract in accordance with the principles established under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq., and contained in the Medicare Provider Reimbursement Manual, HCFA Publication 15-1;

T. Meet the requirements in the Certificate of Need application approved by the Maryland Health Resources Planning Commission;

U. Notify the Medical Assistance Program, in writing, of the contemplated sale of the facility or a controlling interest not less than 30 days before the date of the change of ownership;

V. Assure that an individual who is eligible for Medical Assistance at the time of application for admission to a nursing home, or would become eligible within 6 months following admission, has a long-term care assessment made available before admission, at no charge to the individual, pursuant to COMAR 10.09.30. The evaluation is advisory only and may not restrict the right of an individual to select nursing home services; and

W. Not less than 30 days before the date of any change of ownership, except when the Program agrees to a shorter period, provide the Department the notification and indemnity bond, letter of credit, or certificate of assurance required by Regulation .25D(1)—(3) of this chapter.

.04 Covered Services.

The Program covers routine care and the following supplies, equipment, and services when appropriate to meet the needs of the recipient:

A. Those described in the Maryland Department of Health regulations entitled "Requirements for Long Term Care Facilities", 42 CFR Part 483, Subpart B (1996), subject to limitations in Regulation .05 of this chapter.

B. Over-the-counter drugs.

C. Bed reservations for recipients who are on a leave of absence to visit with friends or relatives or to participate in State-approved therapeutic or rehabilitative programs for a maximum of 18 days in any calendar year and without any limitation on the number of days per visit.

D. Repealed.

E. Administrative days approved by the Department or its designee according to the conditions set forth in Regulation .26D of this chapter.

F. Specialized rehabilitative therapy services which meet the conditions listed below:

(1) Physical Therapy. Physical therapy services for Medical Assistance Program purposes are those services furnished to a recipient which meet all of the following conditions:

(a) The services are directly and specifically related to a plan of care designed by the physician after any needed consultation with the qualified physical therapist;

(b) The services are of such a level of complexity and sophistication or the condition of the recipient needs the judgment, knowledge, or skills of a qualified physical therapist;

The services are performed by or under the supervision of a qualified physical therapist;

(d) The services are provided with the expectation, based on the assessment made by the physician of the recipient's restorative potential after any needed consultation with the qualified physical therapist, that the recipient will improve significantly in a reasonable, and generally predictable, period of time;

(e) The services are considered under accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and

(f) The services are reasonable and necessary to the treatment of the recipient's condition.

(2) Occupational Therapy. Occupational therapy services for Medical Assistance Program purposes are those which meet the following conditions:

(a) The services are directly and specifically related to a plan of care designed by the physician after any needed consultation with the qualified occupational therapist;

(b) The services are on a level of complexity and sophistication or the condition of the recipient needs the judgment, knowledge, and skills of a qualified occupational therapist;

(c) The services are performed by a qualified occupational therapist;

(d) The services are for the purposes of improving or restoring functions which have been impaired by illness or injury or, if function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning;

(e) The services are considered under accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and

(f) The services are reasonable and necessary to the treatment of the recipient's condition.

(3) Speech Therapy. Speech therapy services for Medical Assistance Program purposes are those services furnished to a recipient which meet all of the following conditions:

(a) The services are directly and specifically related to a plan of care designed by the physician after any needed consultation with the qualified speech and language pathologist;

(b) The services are of such a level of complexity and sophistication or the condition of the recipient needs the judgment, knowledge, and skills of a qualified speech and language pathologist;

(c) The services are performed by or under the supervision of a qualified speech and language pathologist;

(d) The services are provided with the expectation, based on the assessment made by the physician of the recipient's restorative potential after any needed consultation with the qualified speech and language pathologist, that the recipient will improve significantly in a reasonable, and generally predictable, period of time;

(e) The services are considered under accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and

(f) The services are reasonable and necessary to the treatment of the recipient's condition.

G. Supplies and equipment necessary to meet the needs of the recipient, including but not limited to:

(1) ABD pads.

(2) Adhesive strip bandages.

(3) Adhesive tape (regular and non-allergenic).

(4) Airways — oral and nasal.

(5) Alcohol and alcohol sponges.

(6) Ambu bags.

(7) Antiseptics and cleansing agents (over-the-counter).

(8) Applicators.

(9) Bandages.

(10) Beds, high-low, adjustable.

(11) Bed pans and urinals.

(12) Bed rails.

(13) Bibs.

(14) Body lotions (over-the-counter).

(15) Canes.

(16) Catheters (including Foley or other indwelling).

(17) Catheter trays.

(18) Chest or body restraints.

(19) Clean catch kits.

(20) Clinical medicine glasses — disposable or otherwise.

(21) Cotton and cotton balls.

(22) Covered water pitchers.

(23) Crutches.

(24) Dentifrices and denture adhesives.

(25) Denture cups.

(26) Deodorant (personal and room).

(27) Diagnostic aids (Clinitest, Acetest, Hematest, Testape, etc.).

(28) Dietary supplements (including tube feeding).

(29) Disposable diapers or incontinency care pads.

(30) Disposable wash cloths.

(31) Douche apparatus.

(32) Drainage bags and catheter tubing.

(33) Emesis basins.

(34) Enema apparatus.

(35) Enemas and douches (including prepared).

(36) Eye pads.

(37) First aid supplies.

(38) Gauzes.

(39) Hot water bottles and covers.

(40) Hydraulic lifts.

(41) Ice bags.

(42) Infusionarm boards.

(43) Intermittent positive pressure breathing machines (I.P.P.B.).

(44) Intravenous poles, portable.

(45) Irrigation trays.

(46) Levine tubes (plastic or regular).

(47) Lubricants and oils.

(48) Mouth washes.

(49) Nasal atomizers.

(50) Needles (cardiac, clysis or intravenous, permanent or disposable).

(51) Oxygen for occasional and emergency use. Continuous oxygen is covered under the provisions of COMAR 10.09.18 Oxygen and Related Respiratory Equipment Services.

(52) Oxygen masks, cannulas, catheters, and related equipment, including portable equipment for use with occasional or emergency oxygen. Equipment used for continuous use oxygen is covered under the provision of COMAR 10.09.18 Oxygen and Related Respiratory Equipment Services.

(53) Paper tissues.

(54) Personal toilet items (toothbrush, soap, shampoo, razor, shaving cream, sanitary pads).

(55) Petroleum jelly.

(56) Powder, medicated or non-medicated—over-the-counter.

(57) Pumps, aspiration and suction.

(58) Rectal tubes.

(59) Rubber or plastic gloves and finger cots.

(60) Rubber or plastic pants.

(61) Rubber or plastic sheeting.

(62) Rubber or sponge rings.

(63) Sand bags.

(64) Scales, including chair scales.

(65) Sheepskin, natural or synthetic.

(66) Slings.

(67) Special mattresses for decubiti care.

(68) Sphygmomanometers.

(69) Stethoscopes.

(70) Stryker and Foster frames.

(71) Suction machines, gastric and tracheal.

(72) Suction tubing.

(73) Surgical dressings, including sterile sponges.

(74) Suture removal kits.

(75) Suture trays.

(76) Syringes, plastic, glass, or bulb.

(77) Tape removers.

(78) Thermometers, oral, rectal, universal, bath.

(79) Tongue depressors.

(80) Tracheostomy equipment and supplies.

(81) Traction equipment.

(82) Trapeze and bed frame equipment.

(83) Trays, cut-down.

(84) Tubing.

(85) Walkers and walkerettes.

(86) Wheel chairs.

H. Administration of enemas.

I. Administration of oxygen.

J. Back rubs.

K. Decubiti care and over-the-counter medication.

L. Colostomy, ileostomy, and nephrostomy care.

M. Hand feeding or self-help eating devices.

N. Incontinency care.

O. Personal laundry.

P. Personal toilet (routine shaving, hair washing and arranging, routine toenail clipping, adequate bathing).

Q. Private room for isolation purposes.

R. Special diets, including diabetic.

S. Tray service.

T. Tube feeding.

U. Portable X-ray services.

V. Respirator management in licensed comprehensive care beds which have been determined by the Department to meet the standards for respiratory care units under COMAR 10.07.02.

W. Intravenous therapy and venipuncture.

X. Noninvasive traction apparatus services (cervical, Buck's extension, pelvic).

Y. Emergency resuscitation procedures, including coronary pulmonary procedures.

Z. Restorative nursing care.

AA. Physician-ordered physical restraints and protective devices.

BB. Negative pressure wound therapy.

.05 Limitations.

The following are not covered:

A. Services by an out-of-State nursing facility unless the Department and the nursing facility execute a provider agreement;

B. Audiology services;

C. Services reimbursed under Title XVIII of the Social Security Act; and

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

.06 Preauthorization Requirements.

A. The Department of Human Services shall certify the recipient for financial eligibility, and the Department or its designee shall certify the recipient as requiring nursing facility services, except as provided in Regulation .26D of this chapter.

B. The Department or its designee will certify as requiring nursing facility services only those financially eligible recipients requiring nursing facility services as defined in Regulation .01B of this chapter.

.07 Prospective Rates.

A. A provider shall be paid the prospective rate for nursing facility services as defined in Regulation .01B of this chapter plus the Nursing Facility Quality Assessment add-on identified in Regulation .11E of this chapter.

B. When necessary, each facility's per diem rate shall be reduced by the same percentage to maintain compliance with the Medicare upper payment limit requirement.

C. Power wheelchairs and bariatric beds are not included in the prospective rate, but may be preauthorized for payment in accordance with COMAR 10.09.12.

D. Support Surfaces.

(1) Support surfaces are not included in the prospective rate.

(2) A provider shall be paid a per diem rate for providing appropriate specialized support surfaces to patients with pressure ulcers or in recovery from myocutaneous flap or graft surgery for a pressure ulcer.

(3) 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 shall 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.

(4) 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 shall 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 E0194 multiplied by 12 and then divided by the number of days in the State fiscal year.

E. Negative pressure wound therapy is not included in the prospective rate, but is reimbursed in accordance with rates established under COMAR 10.09.12. Reimbursement shall include the cost of pumps, dressings, and containers associated with this procedure.

F. Nursing facilities that are owned and operated by the State are not paid in accordance with the provisions of §A of this regulation, but are reimbursed reasonable costs based upon Medicare principles of reasonable costs as described at 42 CFR Part 413. Aggregate payments for these facilities may not exceed Medicare upper payment limits as specified at 42 CFR §447.272. If the Medicare upper payment limit is above aggregate costs for this ownership class, the State may elect to make supplemental payments to increase payments up to the Medicare upper payment limit.

G. Final facility rates for the period July 1, 2020 through June 30, 2021 shall be each nursing facility's quarterly rate, exclusive of the amount identified in Regulation .13A(2) of this chapter, reduced by the budget adjustment factor of 0.405 percent, plus the Nursing Facility Quality Assessment add-on identified in Regulation .11E of this chapter and the ventilator care add-on amount identified in Regulation .13A(2) of this chapter when applicable.

.08 Interim Working Capital Fund.

A. A provider may request an allotment from the Interim Working Capital Fund if the facility for which an allotment is requested has not had any of the following deficiencies cited in any survey conducted by the Office of Health Care Quality during the calendar year preceding the calculation of the allotment, using the scope and severity matrix found in the Centers for Medicare and Medicaid Services State Operations Manual for Survey and Certification, Part 7, §7400E:

(1) Two or more "G" level deficiencies; or

(2) One or more "H" or higher level deficiencies.

B. A provider operating a facility with any of the deficiencies described in §A of this regulation may be eligible for an allotment if the facility has undergone an arm's length change of ownership, as determined by the Department, since the latest survey that resulted in the deficiencies.

C. The Department may deny an allotment from the Interim Working Capital Fund if the Department, based on sufficient information, concludes that the requesting provider is not able to repay the allotment on a timely basis.

D. The maximum allotment for any provider shall be 0.015 times the total Medicaid payments to that provider in the prior State fiscal year.

E. Recalculation.

(1) In March of each year, the Department shall recalculate the maximum allotment based on Medicaid payments for the prior State fiscal year.

(2) If the recalculated maximum allotment is:

(a) Less than the amount the provider carried over from the prior year, the provider shall repay the difference to the Department within 30 days of the date the Department provides notice that a repayment is due; or

(b) Greater than the amount carried over from the prior year, the provider may request the difference from the Department.

F. Revocation.

(1) The Department may revoke the allotment based on:

(a) Quality of care violations;

(b) Changes in business practice that are detrimental to Medicaid recipients;

(c) Impending bankruptcy; or

(d) Other good cause shown.

(2) If the Department revokes the allotment, the provider shall repay the total allotment to the Department within 15 days of the notice of revocation.

G. In order to obtain an allotment, the provider shall agree that it holds the allotment in constructive trust for the State subject to recoupment or immediate payment on demand by the State.

H. The Interim Working Capital Fund expires on May 1, 2021. Providers shall repay all outstanding funds to the Department by May 1, 2021. The Department may grant repayment extensions, not longer than 60 days, under extraordinary circumstances.

.09 Rate Calculation — Administrative and Routine Costs.

A. The Administrative and Routine cost center includes:

(1) Administrative expenses;

(2) Medical records expenses;

(3) Training expenses;

(4) Dietary;

(5) Laundry;

(6) Housekeeping;

(7) Operation and maintenance; and

(8) Capitalized organization and start-up costs.

B. The Department shall initially establish cost center prices for the rate period January 1, 2015 through June 30, 2015, and thereafter rebase the cost center prices between every 2 and 4 rate years. Prices may be rebased more frequently if the Department 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. The Department shall rebase based on the following steps:

(1) The price database shall be established using the most recent desk reviewed Nursing Home Uniform Cost Report for each current provider, or the immediately prior owner of that nursing facility, that is available 2 months before the period for which prices are being established or rebased;

(2) If no desk reviewed cost report is available, that provider shall be excluded from the price database;

(3) The total cost center expenses for each cost report in the price database shall be adjusted from the midpoint of each cost reporting period to the midpoint of the rate year for which the price is being established based on the following steps:

(a) A monthly market basket index shall be calculated based on the following calculations:

Market Basket Index Quarter	Assigned Month	Monthly Index
Quarter 1	January	33 percent of Quarter 4 prior year index plus 67 percent of Quarter 1 index
Quarter 1	February	100 percent of Quarter 1 index
Quarter 1	March	67 percent of Quarter 1 index plus 33 percent of Quarter 2 index
Quarter 2	April	33 percent of Quarter 1 index plus 67 percent of Quarter 2 index
Quarter 2	May	100 percent of Quarter 2 index
Quarter 2	June	67 percent of Quarter 2 index plus 33 percent of Quarter 3 index
Quarter 3	July	33 percent of Quarter 2 index plus 67 percent of Quarter 3 index
Quarter 3	August	100 percent of Quarter 3 index
Quarter 3	September	67 percent of Quarter 3 index plus 33 percent of Quarter 4 index
Quarter 4	October	33 percent of Quarter 3 index plus 67 percent of Quarter 4 index
Quarter 4	November	100 percent of Quarter 4 index
Quarter 4	December	67 percent of Quarter 4 index plus 33 percent of Quarter 1 next year index

(b) The index factor for each cost reporting period shall be calculated by dividing the index associated with the midpoint of the rate year by the index associated with the midpoint of the cost reporting period; and

(c) The indexed costs shall be calculated as total cost center expenses times the index factor;

(4) Each cost report's indexed Administrative and Routine costs shall be 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 to arrive at the Administrative and Routine cost per diem; and

(5) For each reimbursement class, each cost report's Medicaid resident days shall be used in the array of Administrative and Routine cost per diems identified in §B(4) of this regulation to calculate the Administrative and Routine Medicaid day weighted median as follows:

(a) Array the Administrative and Routine cost per diems for each geographic region from low to high;

(b) For each Administrative and Routine cost per diem, identify the Medicaid days from the nursing facilities' cost reports;

(c) Calculate a cumulative Medicaid day total; and

(d) Identify the median Administrative and Routine cost per diem as the Administrative and Routine per diem associated with the cumulative Medicaid days that first equals or exceeds half the number of total Medicaid days for the geographic region.

C. The final price for Administrative and Routine costs for each reimbursement class shall be calculated as the geographic regional Medicaid day weighted median multiplied by 1.025.

D. For years between periods when the prices are rebased, the final cost center price shall be adjusted by the change in the indexes as calculated in §B(3) of this regulation that correspond to midpoint of the prior rate year to the midpoint of the new rate year.

E. The final Administrative and Routine rate for each nursing facility is the Administrative and Routine price for its reimbursement class.

F. The reimbursement classes for the Administrative and Routine cost center are specified under Regulation .30A of this chapter.

G. Kosher Kitchen Add-on.

(1) Nursing facilities that maintain kosher kitchens and have Administrative and Routine costs in excess of the Administrative and Routine price in their reimbursement class that are attributable to dietary expense shall receive an add-on to its final price in an amount up to 15 percent of the median per diem cost for dietary expense in its reimbursement class.

(2) For years between periods when the kosher kitchen add-ons are rebased, the kosher kitchen add-on shall be calculated as the prior year kosher kitchen add-on multiplied by the rate year monthly index divided by the prior year monthly index as identified in §B(3)(a) of this regulation.

.10 Rate Calculation — Other Patient Care Costs.

A. The Other Patient Care cost center includes:

(1) Medical director administrative expenses;

(2) Pharmacy;

(3) Recreational activities;

(4) Patient care consultant services;

(5) Food cost (unprepared);

(6) Social services; and

(7) Religious services.

B. The Department shall initially establish Other Patient Care prices for the rate period January 1, 2015, through June 30, 2015, and thereafter rebase the Other Patient Care prices between every 2 and 4 rate years. Prices may be rebased more frequently if the Department 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. The Department shall rebase based on the following steps:

(1) The indexed costs shall be calculated as set forth in Regulation .09B(1)—(3) of this chapter;

(2) Each cost report's indexed Other Patient Care costs shall be divided by the actual days of nursing facility services to arrive at the Other Patient Care cost per diem;

(3) For each reimbursement class, each cost report's Medicaid resident days shall be used in the array of Other Patient Care cost per diems identified in §B(2) of this regulation to calculate the Other Patient Care Medicaid day weighted median using the method established in Regulation .09B(5) of this chapter;

(4) The final price for Other Patient Care costs for each reimbursement class is calculated as the geographic regional Medicaid day weighted median multiplied by 1.07; and

(5) For years between periods when the prices are rebased, the final price for Other Patient Care costs shall be calculated as set forth in Regulation .09D of this chapter.

C. The final Other Patient Care rate for each nursing facility is the Other Patient Care price for its reimbursement class.

D. The reimbursement classes for the Other Patient Care cost center are specified under Regulation .30B of this chapter.

E. Kosher Kitchen Add-on.

(1) Nursing facilities that maintain kosher kitchens and have Other Patient Care costs in excess of the Other Patient Care price in its reimbursement class that are attributable to food costs shall receive an add-on to its final price an amount up to 15 percent of the median per diem cost for food costs in its reimbursement class.

(2) For years between periods when the kosher kitchen add-ons are rebased, the kosher kitchen add-on shall be calculated as the prior year kosher kitchen add-on multiplied by the rate year monthly index divided by the prior year monthly index as identified in Regulation .09B(3)(a) of this chapter.

.11 Rate Calculation — Capital Costs.

A. The Capital cost center includes:

(1) Real estate taxes; and

(2) Fair rental value.

B. Final Capital Cost.

(1) The determination of a provider's allowable final Capital per diem rate for the cost items under §A of this regulation is calculated as follows:

(a) Appraise each facility at least every 4 years;

(b) 2 months before the period for which final Capital rates are being calculated, determine the most recent appraisal for each facility;

(c) Determine the cost report for each facility that covers the date of valuation of the appraisal identified in §B(1)(b) of this regulation, or, if a cost report covering the date of valuation has not been filed by the facility, determine the closest match to the date of valuation available 2 months before the period for which final Capital rates are being calculated;

(d) Multiply the ending licensed nursing facility beds from the cost report in §B(1)(c) of this regulation, adjusted for accuracy using information available 2 months before setting the rate in this regulation, by the land per bed amount from the appraisal to calculate a total land amount;

(e) Sum the total land amount, building, and equipment;

(f) Divide the total appraisal amount by the number of ending licensed nursing facility beds, under §B(1)(d) of this regulation, to determine an appraised value per bed;

(g) Apply a maximum appraised value per bed of $120,000;

(h) Multiply the final appraised value per bed times the number of ending licensed nursing facility beds, under §B(1)(d) of this regulation, to determine the facility's gross value;

(i) For facilities in Baltimore City, multiply the facility's gross value by 10 percent to determine the facility's annual fair rental value;

(j) For facilities in all jurisdictions except Baltimore City, multiply the facility's gross value by 8 percent to determine the facility's annual fair rental value;

(k) Divide the facility's annual fair rental value by the greater of actual resident days, or days at full occupancy times an occupancy standard calculated under Regulation .09B(4) of this chapter, to establish a fair rental value per diem rate;

(l) Divide real estate taxes obtained from the most recent desk reviewed cost report available 2 months before the start of the rate year by the greater of actual resident days, or days at full occupancy times an occupancy standard calculated under Regulation .09B(4) of this chapter, to establish a real estate tax per diem rate; and

(m) Sum the fair rental value and the real estate tax per diem rates.

(2) The appraisal may not include any value associated with a Certificate of Need for nursing home beds.

C. The final Capital rate for nursing facilities that have a change in the number of licensed beds or have replacement beds placed into operation during a State fiscal year shall not be recalculated as a result of that change until such time as an appraisal incorporating the changes is selected according to §B(1)(b) of this regulation and used in the facility's rate calculation.

D. The provider may protest the appraisal by submitting written notification to the Department within 90 days of receipt of the appraisal. If the protest cannot be resolved administratively, the provider may appeal under Regulation .34 of this chapter.

E. Nursing facilities that are required to pay an assessment in accordance with COMAR 10.01.20.02 shall receive a Quality Assessment add-on calculated as follows:

(1) Sum the assessed days reported on the Nursing Facility Quality Assessment Payment Reporting Forms for the quarters covering the calendar year preceding the rate year;

(2) Multiply the assessed days by the assessment rate established for the rate quarters; and

(3) Divide the total assessed amount by the sum of the total patient days reported on the quarterly Nursing Facility Quality Assessment Payment Reporting Forms.

.12 Rate Calculation — Nursing Service Costs.

A. The Nursing Service cost center includes all nursing expenses related to the direct provision of patient care.

B. The Department shall initially establish Nursing Service prices for the rate period January 1, 2015, through June 30, 2015, and thereafter rebase the Nursing Service prices between every 2 and 4 rate years. Prices may be rebased more frequently if the Department 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. The Department shall rebase based on the following steps:

(1) The indexed costs shall be calculated as set forth in Regulation .09B(1)—(3) of this chapter;

(2) Each cost report's indexed Nursing Service costs shall be divided by the actual days of nursing care to arrive at the indexed Nursing Service cost per diem;

(3) The indexed Nursing Service cost per diem shall be 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 cost report period case mix index rounded to four decimals which creates the Normalized Nursing Cost per diem;

(4) For each reimbursement class, each cost report's Medicaid resident days shall be used in the array of cost per diems identified in §B(3) of this regulation to calculate the Medicaid day weighted median using the method established in Regulation .09B(5) of this chapter;

(5) The final price for Nursing Service costs for each reimbursement class is calculated as the geographic regional Medicaid day weighted median Nursing Service cost multiplied by 1.0825; and

(6) For years between periods when the prices are rebased, the final price for Nursing Service costs shall be adjusted as set forth in Regulation .09D of this chapter.

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

(1) Determine the Nursing Service price for the facility's geographic region;

(2) 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;

(3) Calculate a Medicaid adjusted Nursing Service cost per diem by multiplying the per diem identified under §B(2) or C(5) of this regulation by the Medicaid case mix adjustment ratio calculated as the facility average Medicaid case mix index divided by the cost report period case mix index rounded to four decimals;

(4) Calculate the final Nursing Service rate as the initial nursing facility rate reduced by any positive difference between 95 percent of the initial nursing facility rate and the Medicaid adjusted Nursing Service cost per diem; and

(5) For years between periods when the prices are rebased, the indexed Nursing Service cost per diem identified under §B(2) of this regulation shall be adjusted as set forth in Regulation .09D of this chapter.

D. The reimbursement classes for the Nursing Service cost center are specified under Regulation .30C of this chapter.

E. Resident Rosters.

(1) A nursing facility shall electronically transmit MDS assessment information in a complete, accurate, and timely manner.

(2) The Department shall provide a preliminary resident roster to a nursing facility based on the facility's transmitted MDS assessment information for a calendar quarter on the fifth day of the second month following the end of the calendar quarter, provided that the nursing facility has transmitted the MDS assessment information by the 15th day following the end of the calendar quarter.

(3) The distribution of the preliminary resident roster shall serve as notice of the MDS assessments transmitted and provide an opportunity for the nursing facility to correct and transmit any missing MDS record.

(4) The Department shall provide a final resident roster to a nursing facility based on the facility's transmitted MDS assessment information for a calendar quarter, provided that the nursing facility has transmitted the MDS assessment information by the 25th day

of the second calendar month following the end of the calendar quarter.

(5) The Department may not consider MDS assessment information for the purpose of reimbursement rate calculations for a calendar quarter that is not submitted by the 25th day of the second calendar month following the end of the calendar quarter, except as provided in §E(6) of this regulation.

(6) The Department may only grant an exception to compliance with the electronic MDS assessment transmission due dates if the delay has been caused by fire, flood, act of God, or other good cause.

(7) The Department or its designated contractor shall distribute preliminary and final resident rosters according to the following schedule:

Resident Roster Quarter	Preliminary Resident Roster Distributed	Facility's Revised Resident Roster Transmission Due	Final Resident Roster Distributed
January 1 through March 31	May 5	May 25	June 15
April 1 through June 30	August 5	August 25	September 15
July 1 through September 30	November 5	November 25	December 15
October 1 through December 31	February 5	February 25	March 15

F. Case Mix Index Calculation.

(1) The Department shall use the resource utilization group to adjust Nursing Service costs and to determine each nursing facility's Nursing Service rate component.

(2) The Department shall adjust a nursing facility's case mix reimbursement rates quarterly based on the change in case mix of each facility according to the following schedule:

(a) The facility average Medicaid case mix index obtained from January 1 through March 31 shall be used to adjust rates effective July 1 through September 30 of the same calendar year;

(b) The facility average Medicaid case mix index obtained from April 1 through June 30 shall be used to adjust rates effective October 1 through December 31 of the same calendar year;

(c) The facility average Medicaid case mix index obtained from July 1 through September 30 shall be used to adjust rates effective January 1 through March 31 of the following calendar year; and

(d) The facility average Medicaid case mix index obtained from October 1 through December 31 shall be used to adjust rates effective April 1 through June 30 of the following calendar year.

(3) If the Department or its contractor determines that a nursing facility has delinquent MDS resident assessments, for purposes of determining both facility CMI averages, the assessments shall be assigned the case mix index associated with the RUG group "BC1" or its successor.

(4) A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG classification system, or its successor.

(5) For each resident roster quarter, the Department shall calculate a Statewide average case mix index and a Statewide average Medicaid case mix index from all final resident rosters.

(6) A Medicaid case mix index equalizer shall be used to prevent any aggregate increase or decrease in expected State fiscal year Medicaid program expenditures for the rate quarters beginning every October, January and April, as follows:

(a) The Statewide average Medicaid case mix index for the July rate quarter shall be divided by the Statewide average Medicaid case mix index for the rate quarter identified in §F(2) of this regulation to determine the Medicaid case mix index equalizer for the quarter;

(b) Each facility average Medicaid case mix index for use in the rate quarter for each nursing facility shall be multiplied by the Medicaid case mix index equalizer to result in a facility Medicaid equalized case mix index; and

(c) The facility Medicaid equalized case mix index shall be used in place of the facility Medicaid case mix index in the calculation of the initial and final Nursing Service rate in §C of this regulation for every October, January, and April rate quarter.

(7) To determine cost report period case mix index for cost reporting periods starting before the midpoint of a calendar quarter, the associated quarterly resident roster period CMIs are used. If a cost report end date is before the midpoint of a calendar quarter, the associated quarterly resident roster period CMIs are not used.

G. Assignment of Different Geographic Region.

(1) The Department may approve a provider's request to be included in a different Nursing Service cost center geographic region of this chapter upon review of sufficient documentation. Documentation shall show that the assigned geographic region is not appropriate for the provider and that economic conditions have placed the provider directly in competition with facilities in a geographic region other than the one to which the provider has been assigned by the Department. Payment of higher wages, or higher total expenditures, is not in itself sufficient to demonstrate that the provider is subject to economic conditions different from other providers in its reimbursement class.

(2) All approved waivers for geographic regions shall be effective for the following State fiscal year for the purpose of establishing the final Nursing Service rate in §C of this regulation,

(3) Nursing Service prices established in §B of this regulation shall be based on all facilities in a geographic region that do not have an approved waiver to be included in a different geographic region plus facilities with an approved waiver to receive prices in that geographic region.

.13 Ventilator Care Nursing Facilities.

Nursing facilities with licensed nursing facility beds, which have been determined by the Department to meet the standards for ventilator care under COMAR 10.07.02, shall be reimbursed as follows:

A. Services for residents receiving ventilator care shall be reimbursed as follows:

(1) The Nursing Service rate identified in Regulation .12 of this chapter shall be calculated with a facility average Medicaid case mix index that includes only residents receiving ventilator care; and

(2) An amount of $285 shall be added to the total prospective rate;

B. The facility average Medicaid case mix index for rates under §A of this regulation are not subject to the Medicaid case mix index equalizer adjustment in Regulation .12F(6) of this chapter;

C. Nursing facilities adding ventilator care services for the first time, which have been determined by the Department to meet the standards for ventilator care under COMAR 10.07.02, shall be reimbursed as described in §A of this regulation, except that the facility average Medicaid case mix index is assumed to be that of RUG classification ES3 (or its future equivalent);

D. The facility should request this rate from the Department at least 60 days before the opening of the ventilator unit;

E. For years between periods when the Nursing Services prices are rebased, the final price for Ventilator costs shall be adjusted as set forth in Regulation .09D of this chapter; and

F. For residents not receiving ventilator care, the Initial Facility Nursing Service rate identified in Regulation .12 of this chapter shall be calculated with a facility average Medicaid case mix index that excludes residents receiving ventilator care.

.14 Pay-for-Performance — Eligibility.

In order to be eligible to receive funds through the pay-for-performance program under the provisions of Regulations .15—.19 of this chapter:

A. The provider shall be subject to quality assessment under COMAR 10.01.20; and

B. During the 1 year period ending March 31 of the prior State fiscal year, the provider may not have been:

(1) Identified by the federal Centers for Medicare and Medicaid Services as a special focus facility;

(2) Denied payment for new admissions by the Department; or

(3) Identified by the Department as delivering substandard quality of care.

.15 Pay-for-Performance — Quality Measures.

A. Providers shall receive a composite score based on the following:

(1) Staffing levels, as described in §B of this regulation, shall comprise 20 percent of each facility's score;

(2) Staffing stability, as described in §C of this regulation, shall comprise 15 percent of each facility's score;

(3) Maryland Health Care Commission Nursing Facility Family Survey, as described in §D of this regulation, shall comprise 30 percent of each facility's score;

(4) Minimum Data Set Clinical Quality Indicators, as described in §E of this regulation, shall comprise 30 percent of each facility's score; and

(5) Staff immunization survey, as described in §F of this regulation, shall comprise 5 percent of each facility's score.

B. Staffing Levels.

(1) Staffing and hours of work shall be determined using the Payroll-Based Journal data for the 9-month period ending March 31 of each fiscal year.

(2) A facility's average staffing level shall be determined from its most recent data reported in accordance with §B(1) of this regulation. Total staff hours shall be divided by average daily census during the period specified in §B(1) of this regulation to establish the facility's average daily staffing.

(3) A facility's average acuity shall be determined based on the facilities Minimum Data Set Resource Utilization Groups (RUG) during the 6-month period ending December 31 of the most recent State fiscal year. To establish expected staffing hours, each RUG group will be multiplied by the corresponding hours under Regulation .31B of this chapter and divided by the total days of care during the same period.

(4) The result from §B(3) of this regulation shall be multiplied by 1.26555 to establish the facility's staffing goal.

(5) The facility's staffing level from §B(2) of this regulation shall be divided by the facility's staffing goal from §B(4) of this regulation to determine a score based on its percentage of the goal. A facility staffing exceeding its goal shall be scored at 100 percent.

(6) Providers shall receive 0—20 points based upon the scoring methodology described under Regulation .16 of this chapter.

C. Staff Stability.

(1) On or before May 31 of the fiscal year, nursing facilities, excluding continuing care retirement communities and facilities with fewer than 45 beds, shall report data on individual nursing staff members' length of employment using a format and procedures designated by the Department. This data shall include all nursing staff employed by the facility during the pay period that includes March 31 of the fiscal year.

(2) Providers that fail to comply with §C(1) of this regulation shall receive 0 points.

(3) Staff stability is based upon dates of employment for nursing staff reported in accordance with §C(1) of this regulation.

(4) Staff stability shall be determined by the percentage of staff employed by the facility for 2 years or longer at the time of the report.

(5) Providers shall receive 0—15 points based upon the scoring methodology described under Regulation .16 of this chapter.

D. Family Satisfaction.

(1) Family satisfaction shall be determined based on results from the facility's most recent Nursing Facility Family Survey administered by the Maryland Health Care Commission.

(2) Providers shall receive 0—30 points based upon the scoring methodology described under Regulation .16 of this chapter, as follows:

(a) 0—6 points shall be based upon questions regarding general satisfaction; and

(b) 0—24 points shall be based on several categories of questions regarding specific aspects of care and environment in the nursing facility.

E. Minimum Data Set Clinical Quality Indicators.

(1) Providers shall receive scores for the 3-month period ending December 31 of the most recent prior State fiscal year based on the following quality indicators for long-stay residents from the Minimum Data Set published by the federal Centers for Medicare and Medicaid Services:

(a) Percent of High-Risk Residents Who Have Pressure Sores;

(b) Percent of Residents with a Fall Resulting in Major Injury;

(c) Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder;

(d) Percent of Residents with a Urinary Tract Infection;

(e) Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season; and

(f) Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination.

(2) Providers shall receive 0—5 points for each quality indicator based on the scoring methodology described under Regulation .16 of this chapter.

F. Staff Immunizations.

(1) Providers shall receive a score based on the percentage of nursing facility staff, which includes all staff classifications, that have been vaccinated against seasonal influenza.

(2) Providers shall receive 0, 2, or 5 points for this quality measure. Facilities shall submit data to the Department regarding all individuals employed or contracted by the facility during the period September through April 15.

(3) Benchmark.

(a) The benchmark for staff vaccinations is 90 percent.

(b) Nursing facilities that achieve the benchmark for at least 90 percent but less than 95 percent for seasonal flu shall receive 2 points.

(c) Nursing facilities that meet or exceed the benchmark of 95 percent for seasonal flu shall receive 5 points.

(d) Facilities with less than 90 percent may not receive points for this quality measure.

.16 Pay-for-Performance — Scoring Methodology.

A. Facilities that are eligible for pay-for-performance under Regulation .14 of this chapter shall receive a score for each quality measure described in Regulation .15 of this chapter.

B. For the quality measures described in Regulation .15B—E of this chapter, a facility is ranked and awarded points as follows:

(1) The highest ranked facility receives 100 percent of the points available;

(2) The median score, weighted by total days of care, receives 50 percent of the points available;

(3) Zero points would be received by any facility whose raw score is below the median by an amount equal to or greater than the difference between the highest score and the median score; and

(4) All other facilities will receive points proportionate to where the score falls within the range between the highest and zero.

C. Points for each quality measure are summed.

.17 Pay-for-Performance — Payment for Improvement.

A. In order to be eligible for improvement payment, a facility:

(1) Shall meet the eligibility criteria specified in Regulation .14 of this chapter;

(2) Shall be eligible and receive a composite score during the current fiscal year and the prior fiscal year; and

(3) May not be receiving a payment based upon its score as described in Regulation .19C of this chapter.

B. Facilities shall be ranked according to the greatest point increase compared with the prior fiscal year.

.18 Pay-for-Performance — Scoring Data Review.

A. The Department shall report scores for pay-for-performance quality measures in Regulation .15 of this chapter, on or about July 1 of each year, based on data compiled during the prior fiscal year.

B. A facility shall have 30 days from the date of the report to review and comment on performance data.

C. If the Department determines that there are any errors in transcription of the data provided to the Department, or calculation of scores, ranks, or payment amounts, all facilities shall be rescored and revised scores shall be distributed. A final 30-day review period shall be allowed if the rescoring results in significant modifications.

.19 Pay-for-Performance — Payment Distribution.

A. Beginning State fiscal year 2021, and each year thereafter, 10 percent of the budget allocation for nursing facility services shall be distributed based on pay-for-performance scores.

B. Eighty-five percent of the amount identified in §A of this regulation shall be distributed to the highest scoring facilities, representing 40 percent of the eligible days of care, in accordance with the methodology described in Regulation .16 of this chapter.

C. Funds shall be distributed among the facilities identified in §B of this regulation, based on the facility's relative score, such that the highest-scoring facility shall receive twice the amount per day as the lowest-scoring facility receiving payment.

D. Fifteen percent of the amount identified in §A of this regulation shall be distributed to the facilities that qualify for payment for improvement in accordance with Regulation .17 of this chapter.

E. Funds shall be distributed among the facilities included in §D of this regulation, based on a facility's relative point increase from the prior fiscal year, such that the facility with the greatest point increase shall receive twice the amount per day as the facility with the smallest point increase.

F. A facility shall receive a lump-sum payment based on the per diem amount determined in accordance with §C or E of this regulation, multiplied by the facility's Medicaid days of care in the facility's most recent cost report, not to exceed 1 year.

.20 Payment Procedures — Out-of-State Facilities.

A. Out-of-State nursing facilities that are not special rehabilitation nursing facilities and do not meet the exception to cost reporting requirements set forth in Regulation .21M of this chapter shall be reimbursed at a rate that is the lesser of:

(1) The average Statewide quarterly rate identified by Regulation .07 of this chapter for in-State nursing facilities minus the quality assessment; and

(2) The out-of-State facility's Medicaid per diem rate provided by the state in which the facility is located, or, if the state provides the facility with more than one Medicaid per diem rate, the facility's lowest per diem rate.

B. Out-of-State nursing facilities that are not special rehabilitation nursing facilities and do meet the exception to cost reporting requirements set forth in Regulation .21M of this chapter shall be reimbursed the average Statewide quarterly rate identified by Regulation .07 of this chapter for in-State nursing facilities minus the quality assessment.

C. Out-of-State special rehabilitation nursing facilities shall be reimbursed by the Program when the following conditions are met:

(1) The facility is accredited by the Commission on Accreditation of Rehabilitation Facilities;

(2) The facility is licensed and certified as a nursing facility; and

(3) Services for which reimbursement is requested have been preauthorized by the Program.

D. The rate for each resident in an out-of-State special rehabilitation nursing facility shall be negotiated to:

(1) Be less than the cost of available institutional alternatives; and

(2) Not exceed the home state's Medicaid rate for the same service by the same provider if the provider participates in its home state Medicaid program.

.21 Cost Reporting.

A. The provider shall include, for purposes of cost finding, direct and indirect costs applicable to recipient care.

B. The provider shall specifically identify, in the cost report, costs associated with related organizations.

C. The provider shall maintain adequate financial records and statistical data according to generally accepted accounting principles and procedures. This system of accounts will provide as a minimum:

(1) Maintenance of a chronological cash receipts and disbursements journal in sufficient detail to show the exact nature of the receipts and disbursements;

(2) Proper reference to supporting invoice, voucher, or other form of original evidence;

(3) Maintenance of an appropriate time reporting system for all personnel and proper payroll authorizations and vouchers;

(4) Provision for payment by check (when financial transactions involve numerous small expenditures, an imprest petty cash fund may be established, provided adequate supporting vouchers are maintained);

(5) Maintenance of records on all assets capitalized and depreciation on the assets;

(6) Maintenance of appropriate records of patient days by level of care;

(7) Maintenance of records on an accrual basis;

(8) Maintenance of a daily midnight bed census by recipient name in a form prescribed by the Department (use of the prescribed form may be waived by the Department or its designee where a provider demonstrates the ability to maintain a superior system of census information); and

(9) Maintenance of other records as required by the Department.

D. The provider shall keep all records available for inspection or audit by the Department or its designee at any reasonable time during normal business hours. Upon request by the Department or its designee, documentation of costs shall be made available by the provider during the course of verification. The provider shall have 30 days from the date of the request to provide documentation for undocumented costs. Costs for which documentation is not provided within the 30 days shall be deemed not allowable. The Department may grant, in writing, an extension of time upon written demonstration by the provider of good cause. Records shall be retained for 6 years after the month the cost report to which the materials apply is filed with the Department or its designee.

E. Financial and Statistical Data Required.

(1) The provider shall submit to the Department or its designee, in the form prescribed, financial and statistical data within 3 months after the end of the provider's fiscal year unless the Department grants the provider an extension or the provider discontinues participation in the Program.

(2) If reports are not received within 3 months and an extension has not been granted, the Department shall reduce the per diem rate by 3 percent for services provided during the calendar month after the month in which the report is due and any subsequent calendar month through the month during which the report has been submitted.

(3) If a provider discontinues participation, financial and statistical data shall be submitted to the Department within 45 days after the effective date of termination.

(4) A 1-month extension will be granted upon written request in advance by the provider. The Department may not grant an extension longer than 1 month unless the delay in filing the report has been caused by fire, flood, or act of God, and an extension is not allowed past March 31 after the calendar year during which the provider's fiscal year ended unless the report cannot be submitted by that date due to fire, flood, or act of God.

F. When a report is not submitted by the last day of the sixth month after the end of the provider's fiscal year, the Department shall impose one or more sanctions as provided for in Regulation .33 of this chapter.

G. For purposes of §§E and F of this regulation, reports are considered received when the submitted reports are completed according to instructions issued by the Department or its designee.

H. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.

I. The Department, at its option, may request an additional cost report from a provider when a:

(1) Change in the location of a provider's operation occurs; or

(2) Significant change occurs that would affect the appraised value of a facility, such as an increase in the number of beds by more than 10 percent.

J. If the Department exercises its option under the provisions of §I of this regulation, the period covered by the two reports in the specific provider's fiscal year shall be divided as follows:

(1) Beginning of fiscal year to date of change; and

(2) Date of change through the end of the fiscal year.

K. Except as indicated in §L of this regulation, administrative and routine, other patient care, and capital costs incurred by the provider exclusively for providing ventilator care are not allowed in these cost centers, but are allowable nursing service costs.

L. For any provider who provides ventilator care on 50 percent or more of its Maryland Medical Assistance days of care, all costs incurred by the provider exclusively for providing ventilator care are not allowable costs.

M. A provider which renders a minimal number of Maryland Medical Assistance days of care may not be subject to cost reporting or field verification requirements for a specified fiscal period when the following criteria are met:

(1) The provider bills the Maryland Medical Assistance Program for less than 1,000 Maryland Medical Assistance days of care during the provider's fiscal period; and

(2) The provider gives notice to the Program within 3 months after the end of the provider's fiscal period of the intent to not file a cost report for that period.

N. The notice required in §M(2) of this regulation shall include:

(1) An assurance that the provider billed the Medical Assistance Program for less than 1,000 days of care in the fiscal period; and

(2) A statement that the provider agrees to accept as final reimbursement the average rate paid to all other nursing facilities in the facility's geographic region identified in Regulation .30A of this chapter, minus the quality assessment add-on for facilities that are exempt from Nursing Facility Quality Assessment identified in COMAR 10.01.20.

O. A provider that does not incur costs for over-the-counter drugs on behalf of its private pay residents may adjust its report in order to ensure final reimbursement that more accurately reflects its costs for Medicaid days of care. The provider shall divide its costs by Medicaid and other government-paid days, multiply the quotient by its private pay days of care, and report the product as an adjustment to its over-the-counter drug costs.

.22 Desk Reviews and Field Verification.

A. Desk Reviews.

(1) The Department or its designee may conduct a desk review of the costs before establishing the Administrative and Routine and Other Patient Care prices and Nursing Service rates.

(2) The Department or its designee shall notify each provider participating in the Program if any adjustments resulted from the desk review.

(3) Desk review adjustments shall be used in the computation of any future rate for the facility or the facility's future owner that is based on the reported or desk reviewed costs, until the rate is rebased.

B. Field Verifications.

(1) The Department or its designee may conduct a field verification of the reported or desk reviewed costs affecting reimbursement rates.

(2) The Department or its designee shall notify each provider participating in the Program of the results of the field verification.

(3) Field audit adjustments shall be used in the computation of any future rate for the facility or the facility's future owner that is based on the reported or desk reviewed costs, until the rate is rebased.

(4) Field audit adjustments shall be used in the recomputation of any past rate for the facility or the facility's past owner that is based on the reported or desk reviewed costs.

(5) If the recomputation of rates results in a rate that differs more than 2 percent from the initial rate computation excluding the quality assessment, the Department shall initiate an adjustment for the impacted service dates within 60 days after the notification described in §B(2) of this regulation.

(6) Field audit adjustments shall only affect the facility's rates and do not affect prices or rates for other facilities within the geographic region.

.23 Third Party Liability Reviews and Audits of Nursing Facilities.

A. Quarterly Reports of Credit Balances. A provider shall report the credit balances of the nursing facility to the Department on a quarterly basis.

B. Third Party Liability Review. The Department shall conduct a third party liability review of the reports of the credit balances provider under §A of this regulation.

C. Third Party Liability Audit of Random Sample. The Department or its designee may conduct a third party liability audit of a random sample of the reports of credit balances reviewed under §B of this regulation.

D. Third Party Liability Audit of Noncompliant Nursing Facility.

(1) Subject to §D(2) of this regulation, the Department or its designee may conduct a third party liability audit of a nursing facility that is found to be noncompliant under §B of this regulation.

(2) In conducting the third party liability audit, the Department or its designee may only review the financial information of the nursing facility for the 2-year period immediately before the first day of the audit period in which the nursing facility was found to be noncompliant.

E. Appeal Rights of Nursing Facility.

(1) A provider may appeal the results of a final report of a third party liability audit by filing written notice with the Department within 30 days after the provider receives the final report from the Department.

(2) An individual at the Department who did not participate in the final report shall:

(a) Review the appeal and contact a provider representative, if clarification is necessary; and

(b) Issue a report that either revises or concurs with the final report of the third party audit.

(3) A provider may appeal the results of the report issued by the Department under §E(2) of this regulation by filing written notice with the Nursing Home Appeal Board within 30 days of receipt of the report.

(4) If the provider does not appeal the results of the third party liability audit by filing written notice with the Department:

(a) The amount due as set out in the final report shall be paid to the Department within 60 days of the receipt by the provider of the results of the third party liability audit; or

(b) On or after the 61st day, after receipt by the provider of the results of the third party liability audit, the Department may withhold the amount as set out in the final report from future payments due the provider by the Department unless an agreed on payment plan has been entered into by the Department and the provider.

(5) If the provider appeals the results of a final report of a third party liability audit as authorized under §E(1) of this regulation, interest shall be charged on the amount appealed and shall continue until date of payment. The interest rate shall be based on the 6-month Treasury Bill rate in effect on the date the appeal was filed.

(6) After a decision adverse to the provider by the Nursing Home Appeal Board and written notice to the provider of that decision by the Department:

(a) The amount determined to be due to the Department as a result of the third party liability audit shall be paid to the Department with accrued interest due; or

(b) On or after the 61st day, the Department may withhold the amount due pursuant to the decision of the Nursing Home Appeal Board from future payments due the provider by the Department unless an agreed on payment plan has been entered into by the Department and the provider.

.24 MDS Validation and Ventilator Care Validation.

A. MDS Validation.

(1) In order to validate that the Nursing Service rate is supported by medical record documentation, accurately coded and submitted, the Department shall conduct periodic MDS validation reviews, which shall:

(a) Compare the MDS assessment coding with the corresponding medical record documentation to determine unsupported MDS assessments;

(b) Determine the completeness, timeliness, and accuracy of resident MDS assessments identified on the resident roster; and

(c) Determine the completeness and accuracy of the resident payment source listed on the resident roster.

(2) Findings from the MDS validation may be used to adjust a nursing facility's per diem payment rate to reflect the validated case mix index used in the rate setting process.

B. Ventilator Care Validation.

(1) In order to validate that days paid for residents that meet the requirements for ventilator care are supported by medical record documentation of the need for ventilator care services, the Department shall conduct a periodic ventilator care validation.

(2) Findings from the ventilator care validation shall be used to recoup payments for days not supported by medical record documentation.

.25 New Nursing Facilities, Replacement Facilities, and Change of Ownership.

A. The Department shall establish rates for new nursing facilities, replacement facilities, and nursing facilities with a change of ownership as outlined in §§B—D of this regulation.

B. New Nursing Facilities.

(1) Until such time as an appraisal for the new facility is available as set forth in Regulation .11B(1)(b) of this chapter, the fair rental value per diem rate shall be based on the lower of the facility's construction costs plus the assessed land value divided by the number of licensed beds, or the maximum appraised value per bed in Regulation .11B(1)(g) of this chapter.

(2) A new nursing facility shall be assigned the Statewide average Medicaid CMI until assessment data submitted by the nursing facility is used in a quarterly rate determination.

(3) The nursing facility shall be assigned to the appropriate geographic region, as specified under Regulation .30 of this chapter, for purposes of assigning the Nursing Service rate, the Other Patient Care price, and the Administrative and Routine price.

(4) The geographic region price for Nursing Service costs shall be multiplied by the new nursing facility's Medicaid CMI until there is a nursing facility cost report used in the rebasing process.

(5) The fair rental value per diem rate shall use days as the greater of total estimated resident days or days at full occupancy times an occupancy standard calculated under Regulation .09B(4) of this chapter and the maximum bed value identified in Regulation .11B(1)(g) of this chapter. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation .26F of this chapter, the fair rental value per diem rate shall be calculated using estimated resident days. At the completion of the waiver period, either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(6) Upon providing the real estate bills to the State which incorporate the new construction at least 15 days before the start of operations or at least 15 days before the beginning of any calendar quarter, the real estate tax per diem rate shall be calculated in accordance with Regulation .11B(1)(l) of this chapter. This amount shall be used for the period from the time of submission until the next facility cost report is filed. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation .26F of this chapter, the real estate tax per diem rate shall be calculated using estimated resident days. At the completion of the waiver period, either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(7) For the first 2 State fiscal rate setting years, or portions thereof, new nursing facilities that are required to pay an assessment in accordance with COMAR 10.01.20.02 shall receive a Quality Assessment add-on calculated as follows:

(a) Estimate the assessed days to be reported on the Nursing Facility Quality Assessment Payment Reporting Forms for the quarters covering the upcoming State fiscal rate setting year or portion thereof;

(b) Multiply the estimated assessed days by the assessment rate anticipated for the rate quarters; and

(c) Divide the total estimated assessed amount by the sum of the total estimated patient days. At the completion of either of these first two rate setting periods, either the State or the facility may initiate a settlement payment should the estimates vary from the actual by more than 10 percent.

C. Replacement Facilities.

(1) Until such time as an appraisal for the replacement facility is available as set forth in Regulation .11B(1)(b) of this chapter, the fair rental value per diem rate shall be based on the lower of the facility's construction costs plus the assessed land value divided by the number of licensed beds, or the maximum appraised value per bed in Regulation .11B(1)(g) of this chapter.

(2) The fair rental value per diem rate shall use days as the greater of total estimated resident days or days at full occupancy times an occupancy standard calculated as the Statewide average under Regulation .09B(4) of this chapter. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation .26F of this chapter the fair rental value per diem rate shall be calculated using estimated resident days. At the completion of the waiver period either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(3) Upon providing the real estate bills to the State, which incorporate the new construction, at least 15 days before the start of operations or at least 15 days before the beginning of any calendar quarter, the real estate tax per diem rate shall be calculated in accordance with Regulation .11B(1)(l) of this chapter. This amount shall be used for the period from the time of submission until the next facility cost report is filed. For the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation .26F of this chapter, the real estate tax per diem rate shall be calculated using estimated resident days. At the completion of the waiver period either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

(4) The replacement facility fair rental value rate shall be effective beginning on the date the replacement facility meets the requirements in Regulations .02 and .03 of this chapter.

(5) Except for the fair rental value portion of the Capital rate, the replacement facility shall be paid exactly as the original facility.

(6) The replacement facility rates shall be based on the original facility's average Medicaid case mix index and cost report costs.

D. Change of Ownership.

(1) Except when the Program agrees to a shorter notification period, when there is an anticipated change of ownership of a provider, not less than 30 days before the date of the change of ownership:

(a) The provider shall:

(i) Notify the Program of the anticipated change of ownership; and

(ii) If the provider has not filed for bankruptcy, post an indemnity bond or a standby letter of credit, or provide assurance satisfactory to the Program that the purchaser shall assume and be responsible for all financial obligations of the existing provider; and

(b) The purchaser shall:

(i) Notify the Program of the intent to engage in a change of ownership and the desire to enroll in the Program;

(ii) Submit a provider application and execute a provider agreement with the Department; and

(iii) If the provider has filed for bankruptcy, post an indemnity bond or a standby letter of credit, or provide some assurance satisfactory to the Program that the purchaser shall assume and be responsible for all financial obligations of the existing provider.

(2) Indemnity Bond or Standby Letter of Credit.

(a) The indemnity bond or standby letter of credit required by §D(1)(a)(ii) or (b)(iii) of this regulation shall be in the amount of:

(i) 10 percent of the Program billings for each unsettled fiscal period prior to January 1, 2015 outstanding;

(ii) All unpaid amounts due and owing the Program for each settled fiscal period before January 1, 2015;

(iii) 5 percent of the Program billings for the most recent annual fiscal period; and

(iv) All debt owed by the provider to the Interim Working Capital Fund under Regulation .08 of this chapter.

(b) The indemnity bond or standby letter of credit obligation under §D(2)(a) of this regulation shall remain in effect until all financial liabilities are resolved.

(c) If a court of competent jurisdiction discharges the debt of a bankrupt provider, the Program shall release to the purchaser the difference between the indemnity bond or standby letter of credit required under §D(1)(b)(iii) of this regulation and the amount of the financial obligation discharged by the court.

(3) The purchaser shall submit a provider application and execute a provider agreement with the Department before being assigned a prospective rate.

(4) The new owner shall assume the old owner's facility average Medicaid case mix index and cost reports.

(5) The new owner shall be paid at the same rates as the old nursing facility provider except for the period of time the facility is operating under a waiver of occupancy granted in accordance with Regulation .26F of this chapter in which the Capital rate shall be calculated using estimated resident days. At the completion of the waiver period either the State or the facility may initiate a settlement payment should the estimate vary from the actual by more than 10 percent.

.26 Selected Costs — Allowable.

A. Recreational Services. The allowable costs of recreational services of a facility shall be based on an hourly or salary rate, not on a fee-for-service basis.

B. Over-the-Counter Drugs. The cost of over-the-counter drugs is not to exceed the average wholesale price plus 50 percent, or the usual selling price, whichever is lower.

C. Leave of Absence. The Department shall pay the sum of the rates identified in Regulations .09—.11 of this chapter, less patient resources for the cost of reserving beds for recipients for therapeutic home visits or participation in State-approved therapeutic or rehabilitative programs, subject to the following conditions:

(1) The recipient's plan of care provides for the absence;

(2) The leave of absence does not exceed 18 days during any calendar year;

(3) The recipient's attending physician shall complete the physician's authorization form not more than 30 days before the recipient's anticipated leave of absence; and

(4) The facility submits the physician's authorization form to the Department with the facility's invoice, which covers the month in which the leave of absence occurred.

D. Administrative Days. The Department shall pay the sum of the rates identified in Regulations .09—.11 of this chapter, and 50 percent of the rate identified in Regulation .12 of this chapter, less patient resources for administrative days, documented on forms designated by the Department, which satisfy the following conditions:

(1) The recipient's required level of care has changed, and the following conditions are met:

(a) The Department or its designee has determined that the recipient's level of care is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);

(b) The provider has implemented a predischarge planning program and initiated placement activities for the recipient at the earliest appropriate time;

(c) The provider has actively pursued placement of the recipient at the required level of care in an appropriate facility during the entire period of administrative days;

(d) The provider has submitted documentation to the Department or its designee that it has complied with the requirements of §D(1)(a)—(c) of this regulation for the entire period of the administrative stay claimed for reimbursement; and

(e) The recipient is transferred promptly to the first available appropriate facility licensed and certified for the required level of care;

(2) When institutional care is no longer appropriate, and the following conditions are met:

(a) The Department or its designee has determined that the recipient no longer requires the level of care, which is provided by a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);

(b) The provider has implemented a predischarge planning program and initiated placement activities for the recipient at the earliest appropriate time;

(c) The provider has actively pursued placement of the recipient at the required level of care at home or in an appropriate setting during the entire period of administrative days;

(d) The provider has submitted documentation to the Department or its designee that it has complied with the requirements of §D(2)(a)—(c) of this regulation for the entire period of the administrative stay claimed for reimbursement; and

(e) The recipient is transferred promptly after appropriate placement has been found; and

(3) When the recipient is at an inappropriate level of care but cannot be moved, and the following conditions are met:

(a) The attending physician has declared that, because of physical or emotional problems, the recipient is unable to be moved;

(b) The reason the recipient cannot be moved is adequately documented by the attending physician in the recipient's record; and

(c) Reevaluation by the attending physician of the recipient's inability to be moved and appropriate documentation of it in the recipient's record have been made at least every 60 days.

E. Bed Occupancy. The Statewide average occupancy, defined in Regulation .09B(4) of this chapter, shall be calculated after the exclusion of all providers which operated under a waiver of the occupancy standard during any part of the cost report period.

F. A waiver of the occupancy standards defined in Regulation .09B(4) of this chapter may be made by the Department under the following conditions:

(1) During a period not to exceed the first 12 months of operation for a newly constructed facility or for a newly constructed portion of an existing facility;

(2) During periods throughout which the occupancy standard could not be attained due to labor strike, fire, flood, or act of God, when this event is reported to the State licensing authority within 10 days of the event and request for waiver is submitted to the Program within 30 days of the event;

(3) For a period not to exceed 12 months when a voluntary reduction in licensed nursing facility bed capacity has been granted by the Department and the provider has received prior approval from the Program to reduce available beds while renovations are being completed;

(4) For a period not to exceed 12 months after a new provider acquires an existing facility which has been operated by the previous provider below the occupancy standard due to a ban on admissions, and when prior approval for the waiver has been granted by the Program;

(5) For a period not to exceed 12 months after a new provider acquires an existing facility which was in bankruptcy and operated below the occupancy standard at the time of purchase; or

(6) For a period not to exceed 12 months after a new provider has acquired or leased a building that was not licensed as a nursing facility immediately before the provider's acquisition or lease.

G. When a waiver is granted under the provisions of §F(3) of this regulation, the occupancy standards shall be applied to the reduced licensed capacity.

H. A waiver of the occupancy standards defined in Regulation .09B(4) of this chapter may not be allowed due to a ban on admissions or under any circumstances other than those described in §F of this regulation.

I. Rates that are determined in accordance with the provisions of §F of this regulation are effective only for the period during which the waiver of the occupancy standard is in effect.

.27 Selected Costs — Not Allowable.

The following costs are not allowable in establishing prospective rates:

A. Costs not adequately documented;

B. Costs for chaplaincy training and other religious training programs;

C. Bad debts incurred by private pay or Medicare patients or third-party payers and bad debts resulting from denied costs of the Program;

D. Recipient resources certified as available for medical and remedial care by the Department of Human Services which are uncollected;

E. Advertising expenses, except those necessary for personnel recruitment;

F. Stockholder costs incurred primarily for the benefit of stockholders or other investors, including the costs of stockholders' annual reports and newsletters, annual meetings, mailing of proxies, stock transfer agent fees, stock exchange registration fees, stockbroker and investment analysis, stock issuance costs, and accounting and legal fees for consolidating statements for Securities and Exchange Commission purposes;

G. Any contributions, whether charitable or not, to any individual or organization;

H. Public relations expenses;

I. Costs of maintaining a recipient in a private room which exceeds costs of a semiprivate room;

J. Cost of depreciable assets and minor equipment useful for a lifetime of at least 2 years, with a historical cost of at least $500 or an aggregate historical cost of at least $500 if they are purchased in a quantity of like or similar items;

K. Civil money penalties, fines, and all costs associated with sanctions, including receivership, initiated by the Department or any other local, State, or federal government agency;

L. Interest paid by a provider under Regulation .23E(5) of this chapter;

M. Administrator compensation for any owner, or relative of the owner, in excess of the limits established based on the results of the 2001 nonowner administrator compensation survey, trended forward based on the percentage of the annual increase or decrease in the All Items category of the Consumer Price Index for All Urban Consumers (CPI-U), as follows:

(1) For facilities with 1—74 beds, the median compensation from that group;

(2) For facilities with 75—199 beds, the median compensation from that group; and

(3) For facilities with 200 or more beds, the median compensation from all facilities with 200 or more beds;

N. Compensation for any administrator, who is not an owner, or relative of the owner, in excess of the limits established based on the results of the 2001 nonowner administrator compensation survey, trended forward based on the percentage of the annual increase or decrease in the All Items category of the Consumer Price Index for All Urban Consumers (CPI-U), as follows:

(1) For facilities with 1—74 beds, the 75th percentile compensation from that group plus 15 percent;

(2) For facilities with 75—199 beds, the 75th percentile compensation from that group plus 15 percent;

(3) For facilities with 200—299 beds, the 75th percentile compensation from all facilities with 200 or more beds plus 15 percent; and

(4) For facilities with 300 or more beds, 15 percent more than the limit established in §N(3) of this regulation for the facilities with 200—299 beds;

O. Assistant administrator compensation for any owner, or relative of the owner, in excess of 80 percent of the maximum administrator compensation for the facility established in accordance with §M of this regulation;

P. Compensation for any assistant administrator, who is not an owner, or relative of the owner, in excess of 80 percent of the maximum administrator compensation for the facility established in accordance with §N of this regulation;

Q. Central office employee compensation for any owner or relative of the owner in excess of the amount established in accordance with §M of this regulation, for the bed size category determined as the sum of beds if multiple facilities, plus 10 percent;

R. Compensation for any central office employee, who is not an owner, or relative of the owner, in excess of the amount established in accordance with §N of this regulation, for the bed size category determined as the sum of beds if multiple facilities, plus 10 percent;

S. Costs incurred in any effort to acquire a Certificate of Need or an exemption from a Certificate of Need for nursing home beds;

T. Costs incurred for specialized support surfaces used for pressure ulcer care;

U. Legal, accounting, and other professional expenses related to an appeal challenging a payment determination pursuant to Regulations .23E and .34 of this chapter unless a final adjudication is issued sustaining the nursing facility's appeal;

V. A percentage of the legal, accounting, and other professional expenses related to an appeal as described in §U of this regulation, based upon the proportion of additional reimbursement denied to the total additional reimbursement sought on appeal, if a facility prevails on some but not all issues raised in the appeal or action;

W. Any charges assessed by the Department for recovery of overpayments; and

X. Direct service costs for physical, occupational, and speech therapy.

.28 Recipient's Resource.

A. The Department of Human Services will determine the application of a recipient's resource to the cost of medical or remedial care pursuant to COMAR 10.09.24.

B. The provider shall collect a recipient's resource available for medical or remedial care, as certified by the Department of Human Services.

C. The total of a recipient's available resource for medical or remedial care and the Department's payment may not exceed the provider's per diem rate.

D. The provider shall show sums collected from a recipient's available resource as patient revenue.

.29 Recipient's Personal Needs Fund.

A. If a provider administers a recipient's personal needs fund, it shall administer the fund according to guidelines established by the Department.

B. Upon request during normal business hours, a provider shall make available for verification by the Department or its designee the records of all transactions involving recipient's personal needs funds.

C. A provider may not use a recipient's personal needs fund for care or services which are either allowable as part of the per diem cost or otherwise covered by the Medical Assistance Program.

D. Upon request during normal business hours, 7 days a week, for a minimum of 3 hours each day, a provider shall allow a recipient to withdraw or otherwise use his personal needs fund.

E. A provider may not use a recipient's personal needs fund for care or services not requested or not provided. A recipient's personal needs fund may not be used to retire a pre-existing debt.

.30 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;

(1-1) Facilities in Baltimore City;

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

(a) Charles;

(b) Montgomery; and

(c) Prince George's;

(3) 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. For services provided prior to July 1, 2019, 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.

D. Effective July 1, 2020, the reimbursement classes for the Nursing Service cost center are as follows:

(1) Facilities in the Baltimore Metro region consisting of Baltimore City and the following counties:

(a) Anne Arundel;

(b) Baltimore;

(c) Carroll;

(d) Cecil;

(e) Harford; and

(f) Howard;

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

(a) Calvert;

(b) Charles;

(c) Frederick;

(d) Montgomery;

(e) Prince George's; and

(f) St. Mary's;

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

(a) Caroline;

(b) Dorchester;

(c) Kent;

(d) Queen Anne's;

(e) Somerset;

(f) Talbot;

(g) Wicomico; and

(h) Worcester; and

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

(a) Allegany;

(b) Garrett; and

(c) Washington.

E. During the period July 1, 2019 through June 30, 2020, reimbursement for the Nursing Service cost center shall be the sum of 50 percent of the amount calculated in accordance with the reimbursement classes under §C of this regulation and 50 percent of the amount calculated in accordance with the reimbursement classes under §D of this regulation.

.31 Nursing Service Personnel and Procedures.

A. Personnel Types and Category Groupings.

Selected Personnel Types	*Personnel Categories*
Director of nursing (RN or LPN)	Directors of nursing (DON)
Assistant director of nursing (RN or LPN)	
RN charge nurse	Registered nurses (RN)
RN staff nurse	
RN relief nurse	
Registry RN charge nurse	
Registry RN staff nurse	
LPN charge nurse	Licensed practical nurses (LPN)
LPN staff nurse	
LPN relief nurse	
Registry LPN charge nurse	
Registry LPN staff nurse	
Graduate nurse	
Nurse aide	Nurse aides (NA)
Nurse aide relief	
Registry nurse aide	
Ward clerk	
Certified medication aide	Certified medication aide (CMA)

B. Minimum Data Set Resource Utilization Groups Hourly Weights.

RUG-IV 48 Total Hours ES3 6.17733333 ES2 5.04483333 ES1 5.69500000 RAE 5.17450000 RAD 4.70150000 RAC 3.86266667 RAB 3.07583333 RAA 2.28500000 HE2 5.43733333 HE1 4.49366667 HD2 5.00533333 HD1 3.99700000 HC2 4.26566667 HC1 3.84616667 HB2 5.30500000 HB1 3.02300000 LE2 4.89816667 LE1 4.01933333 LD2 4.31583333 LD1 3.35383333 LC2 3.32883333 LC1 3.36916667 LB2 4.07566667 LB1 2.91083333 CE2 4.28650000 CE1 3.86816667 CD2 4.46816667 CD1 3.80533333 CC2 3.02250000 CC1 2.98650000 CB2 2.83283333 CB1 2.68883333 CA2 1.87200000 CA1 1.75983333 BB2 2.49116667 BB1 2.46466667 BA2 2.12716667 BA1 1.65100000 PE2 3.84716667 PE1 3.81933333 PD2 3.74566667 PD1 3.46050000 PC2 2.68133333 PC1 2.90283333 PB2 2.74100000 PB1 2.00416667 PA2 1.07683333 PA1 1.34950000

.32 Recovery and Reimbursement.

A. If the recipient has insurance or other coverage, or if any other person is obligated, either legally or contractually, to pay for or to reimburse the recipient for any service covered by this chapter, the provider shall seek payment from that source first. If an insurance carrier rejects the claim or pays less than the amount allowed by the Medical Assistance Program, the provider may submit a claim to the Program. The provider shall submit a copy of the insurance carrier's notice or remittance advice with his invoice. If payment is made by both the Program and the insurance or other source for the same service, the provider shall refund to the Department, within 60 days of receipt, the amount paid by the Program, or the insurance or other source, whichever is less.

B. The provider shall reimburse the Department for any overpayment.

C. If the recipient is eligible for benefits from another payment source and elects to forfeit those benefits, the Program may reduce payment by the value of the benefits forfeited.

.33 Cause for Suspension or Removal and Imposition of Sanctions.

A. If the Department determines that a provider, any agent or employee of the provider, or any person with an ownership interest in the provider has failed to comply with applicable federal or State laws or regulations, the Department may initiate one or more of the following actions against the responsible party:

(1) Suspension from the Program;

(2) Withholding of payment by the Program;

(3) Removal from the Program;

(4) Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed;

(5) Denial of payment for new Medicaid admissions.

A-1. Federal Remedies. If the Department determines that a provider is not in substantial compliance with federal requirements for participation in the Program, the Department may impose any of the remedies available under 42 CFR Part 488, Subpart F—Enforcement of Compliance for Long-Term Care Facilities with Deficiencies. The Department shall use the criteria set forth in 42 CFR Part 488, Subpart F, as the basis for imposing these remedies.

B. If the Secretary of Health and Human Services suspends or removes a provider from participation in Medicare, the Department will take similar action.

C. The Department will give reasonable written notice to the nursing facility, to recipients, recipient's next of kin, and others who may be affected, of its intention to impose sanctions. The written notice will state the effective date and specific reasons for the proposed action, and advise the provider of the right to appeal.

D. A provider who voluntarily withdraws from the Program or is removed or suspended from the Program according to this regulation shall notify recipients that he no longer honors Medical Assistance cards before he renders additional services.

.34 Appeal Procedures.

A. Except as provided for in §B of this regulation, providers filing appeals from administrative decisions made in connection with these regulations shall do so according to COMAR 10.09.36.09.

B. Nursing Home Appeal Board.

(1) Appeals regarding rate calculations or cost report adjustments which cannot be resolved administratively go to the Nursing Home Appeal Board.

(2) The Appeal Board shall be composed of the following members:

(a) A representative of the nursing home industry who is:

(i) Knowledgeable in Medicare and Medicaid reimbursement principles; and

(ii) Appointed by the Secretary;

(b) An individual who:

(i) Is employed by the State;

(ii) Knowledgeable in Medicare and Medicaid reimbursement principles;

(iii) Did not directly participate in the field verification or desk review; and

(iv) Is appointed by the Secretary; and

(c) A third member selected by the first two members of the Board.

(3) When the Board is reviewing an appeal from a provider in which a Board member is employed or in which he has a financial or personal interest, the Secretary shall designate an alternate for that member.

(4) If the provider elects to appeal to the Appeal Board and the Appeal Board finds in favor of the provider, the Department shall initiate a claims adjustment settlement for the impacted service dates within 60 days after the notification of the findings.

(5) The Department or any provider aggrieved by a reimbursement decision of the Appeal Board may not appeal to the Board of Review but may take a direct judicial appeal. The appeal shall be made as provided for judicial review of final decisions in the Administrative Procedure Act, §10-222, State Government Article, Annotated Code of Maryland.

(6) An appeal shall be filed in accordance with COMAR 10.01.09.

.35 Interpretive Regulation.

Except when the language of a specific regulation indicates an intent by the Department to provide reimbursement for covered services to Program recipients without regard to the availability of federal financial participation, State regulations shall be interpreted in conformity with applicable federal statutes and regulations.

Administrative History

Effective date: July 9, 1975 (2:15 Md. R. 1070)

Regulation .03E amended effective January 30, 1976 (3:4 Md. R. 216)

Regulation .03H amended effective December 31, 1975 (3:4 Md. R. 216)

Regulation .03Q adopted as an emergency provision effective July 1, 1977 (4:15 Md. R. 1143); adopted permanently effective October 21, 1977 (4:22 Md. R. 1671)

Regulation .03X amended effective September 29, 1976 (3:20 Md. R. 1143)

Regulation .05 amended effective August 17, 1977 (4:17 Md. R. 1298)

Regulation .06 amended as an emergency provision effective April 1, 1977 (4:8 Md. R. 631); emergency status extended at 4:17 Md. R. 1291)

Regulation .06 amended effective August 17, 1977 (4:17 Md. R. 1298)

Regulation .06B amended effective January 30, 1976 (3:4 Md. R. 216)

Regulation .06C adopted as an emergency provision effective July 1, 1977 (4:15 Md. R. 1143); adopted permanently effective October 21, 1977 (4:22 Md. R. 1671)

Regulation .07 amended effective August 17, 1977 (4:17 Md. R. 1298)

Regulation .09 amended effective August 17, 1977 (4:17 Md. R. 1298)

Regulation .09A amended effective September 29, 1976 (3:20 Md. R. 1143)

Regulation .09B amended as an emergency provision effective April 1, 1977 (4:8 Md. R. 631); emergency status extended at 4:17 Md. R. 1291

Regulation .09B, D amended effective January 30, 1976 (3:4 Md. R. 216)

Regulation .09A amended as an emergency provision effective July 1, 1977 (4:15 Md. R. 1143); amended permanently effective October 21, 1977 (4:22 Md. R. 1671)

Regulation .09A amended as an emergency provision effective June 13, 1978 (5:13 Md. R. 1039)

Regulations .03 and .09 amended as an emergency provision effective January 1, 1978 (5:1 Md. R. 15)

Regulations .03, .06, .08, and .09 amended as an emergency provision effective March 15, 1978 (5:9 Md. R. 681)

Chapter revised effective July 1, 1978 (5:13 Md. R. 1051)

Regulations .01U, HH, II, LL; .02; .03; .04G; .07; .09; .11E amended effective December 14, 1979 (6:25 Md. R. 1980)

Regulation .01M-1 and M-2 adopted effective July 1, 1980 (7:13 Md. R. 1278)

Regulations .01O, .03D, and .11E amended effective January 1, 1980 (6:26 Md. R. 2074)

Regulations .01JJ, KK; .07-1; .08A-1 adopted effective December 14, 1979 (6:25 Md. R. 1980)

Regulation .01P repealed effective January 1, 1980 (6:26 Md. R. 2074)

Regulation .05A repealed effective December 14, 1979 (6:25 Md. R. 1980)

Regulation .07B amended as an emergency provision effective July 1, 1978 (5:14 Md. R. 1132); adopted permanently effective November 3, 1978 (5:22 Md. R. 1673)

Regulation .07-2 adopted effective July 1, 1980 (7:13 Md. R. 1278)

Regulation .08E amended as an emergency provision effective July 1, 1978 (5:14 Md. R. 1131); adopted permanently effective November 3, 1978 (5:22 Md. R. 1673)

Regulation .11 amended effective December 20, 1982 (9:25 Md. R. 2482)

Regulation .16A, B amended effective August 17, 1981 (8:16 Md. R. 1365)

Regulation .18 adopted effective October 25, 1982 (9:21 Md. R. 2106)

Chapter revised effective January 1, 1983 (9:25 Md. R. 2480)

Regulation .01B amended effective June 6, 1983 (10:11 Md. R. 975); August 10, 1987 (14:16 Md. R. 1773)

Regulation .01B amended as an emergency provision effective July 1, 1986 (13:14 Md. R. 1627); adopted permanently effective December 1, 1986 (13:21 Md. R. 2320)

Regulation .03 amended as an emergency provision effective February 18, 1983 (10:6 Md. R. 536)

Regulation .03P amended, Q adopted effective June 6, 1983 (10:11 Md. R. 975)

Regulation .03R adopted effective January 30, 1984 (11:2 Md. R. 113)

Regulation .03S adopted effective July 28, 1986 (13:15 Md. R. 1734)

Regulation .03T and U adopted effective August 10, 1987 (14:16 Md. R. 1773)

Regulation .04G amended effective October 29, 1984 (11:21 Md. R. 1812)

Regulation .05 amended effective June 1, 1988 (15:11 Md. R. 1331)

Regulation .07B amended and .07H adopted as an emergency provision effective June 27, 1983 (10:14 Md. R. 1257); adopted permanently effective October 24, 1983 (10:21 Md. R. 1901)

Regulation .07B amended effective June 6, 1983 (10:11 Md. R. 975); August 10, 1987 (14:16 Md. R. 1773)

Regulation .07B and E amended effective July 1, 1984 (11:12 Md. R. 1063)

Regulation .07B, C, F, G amended and .07C-1 adopted as an emergency provision effective July 1, 1986 (13:15 Md. R. 1729); adopted permanently effective December 1, 1986 (13:22 Md. R. 2398)

Regulation .07C amended effective October 29, 1984 (11:21 Md. R. 1812)

Regulation .07D amended effective July 18, 1983 (10:14 Md. R. 1262); July 1, 1987 (14:13 Md. R. 1473); June 1, 1988 (15:11 Md. R. 1331); July 1, 1988 (15:13 Md. R. 1553)

Regulation .07D amended as an emergency provision effective January 26, 1988 (15:4 Md. R. 469); adopted permanently effective May 15, 1988 (15:8 Md. R. 1009)

Regulation .07E amended effective January 27, 1986 (13:2 Md. R. 137); July 1, 1988 (15:13 Md. R. 1533); September 5, 1988 (15:18 Md. R. 2147)

Regulation .07E amended as an emergency provision effective July 1, 1986 (13:14 Md. R. 1627); adopted permanently effective December 1, 1986 (13:21 Md. R. 2320)

Regulation .07G amended effective December 29, 1986 (13:26 Md. R. 2807)

Regulation .07H repealed effective August 10, 1987 (14:16 Md. R. 1773)

Regulation .08 amended as an emergency provision effective July 1, 1985 (12:14 Md. R. 1427); emergency status expired November 4, 1985

Regulation .08 amended effective November 4, 1985 (12:22 Md. R. 2103)

Regulation .09A amended effective September 5, 1988 (15:18 Md. R. 2147)

Regulation .10E amended effective August 10, 1987 (14:16 Md. R. 1773)

Regulation .10I amended effective January 30, 1984 (11:2 Md. R. 113); September 10, 1984 (11:18 Md. R. 1584)

Regulation .12D repealed effective August 10, 1987 (14:16 Md. R. 1773)

Regulation .13E amended as an emergency provision effective January 1, 1983 (10:1 Md. R. 21); adopted permanently effective May 1, 1983 (10:7 Md. R. 634)

Regulation .13F amended as an emergency provision effective July 1, 1986 (13:15 Md. R. 1729); adopted permanently effective December 1, 1986 (13:22 Md. R. 2398)

Regulation .14K adopted as an emergency provision effective June 27, 1983 (10:14 Md. R. 1257); adopted permanently effective October 24, 1983 (10:21 Md. R. 1901)

Regulation .14K repealed effective August 10, 1987 (14:16 Md. R. 1773)

Regulation .17A amended effective May 12, 1986 (13:9 Md. R. 1029)

Regulation .19 amended effective June 6, 1983 (10:11 Md. R. 974)

Chapter revised effective November 27, 1989 (16:23 Md. R. 2505)

Regulations .01, .07—.12, .16, and .25 amended as an emergency provision effective January 14, 1992 (19:3 Md. R. 299); emergency status expired June 30, 1992

Regulations .01, .07—.13, .16, .17, .23, and .25 amended as an emergency provision effective July 1, 1992 (19:14 Md. R. 1272); amended permanently effective November 1, 1992 (19:21 Md. R. 1891)

Regulations .01, .04, .08—.11, .16, .17, .20, .21, and .23 amended as an emergency provision effective July 1, 2005 (32:19 Md. R. 1584); emergency status expired August 31, 2005

Regulation .01B amended effective March 19, 1990 (17:5 Md. R. 638); December 29, 1997 (24:26 Md. R. 1758)

Regulation .01B amended as an emergency provision effective May 1, 2004 (31:12 Md. R. 908); amended permanently effective August 16, 2004 (31:16 Md. R. 1255)

Regulation .01B amended effective May 9, 2005 (32:9 Md. R. 848); December 9, 2005 (32:24 Md. R. 1904)

Regulation .01B amended as an emergency provision effective July 16, 2009 (36:17 Md. R. 1310); amended permanently effective October 5, 2009 (36:20 Md. R. 1527)

Regulation .01B amended effective January 24, 2011 (38:2 Md. R. 84); October 3, 2011 (38:20 Md. R. 1202); October 14, 2013 (40:20 Md. R. 1652)

Regulation .02 amended effective December 29, 1997 (24:26 Md. R. 1758)

Regulation .03 amended effective March 19, 1990 (17:5 Md. R. 638); December 29, 1997 (24:26 Md. R. 1758)

Regulation .03V amended effective October 3, 2011 (38:20 Md. R. 1202)

Regulation .03W adopted effective October 3, 2011 (38:20 Md. R. 1202)

Regulations .04, .10L, .11F, O, and .25B amended as an emergency provision effective July 3, 1990 (17:16 Md. R. 1986); amended permanently effective November 1, 1990 (17:21 Md. R. 2529)

Regulations .04, .05, .07—.11, .13, .16, and .25 amended and new Regulation .09-1 adopted as an emergency provision effective October 1, 1999 (26:23 Md. R. 1775); adopted permanently effective January 9, 2000 (26:27 Md. R. 2015)

Regulation .04 amended effective August 15, 1994 (21:16 Md. R. 1383); December 29, 1997 (24:26 Md. R. 1758)

Regulation .04D repealed effective March 18, 2013 (40:5 Md. R. 411)

Regulation .04E amended effective December 9, 2005 (32:24 Md. R. 1904); March 18, 2013 (40:5 Md. R. 411)

Regulation .04BB adopted as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .04BB adopted effective September 22, 2008 (35:19 Md. R. 1716)

Regulation .05 amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .05 amended effective February 16, 2004 (31:3 Md. R. 207)

Regulation .05G amended effective December 29, 1997 (24:26 Md. R. 1758)

Regulation .06 amended effective December 29, 1997 (24:26 Md. R. 1758); July 8, 2002 (29:13 Md. R. 990)

Regulations .07—.11 amended as an emergency provision effective December 1, 2001 (29:1 Md. R. 17)

Regulations .07—.11-1 and .26 amended as an emergency provision effective July 1, 1995 (22:15 Md. R. 1114); emergency status expired November 1, 1995; amended permanently effective November 6, 1995 (22:22 Md. R. 1658)

Regulation .07 amended effective July 8, 2002 (29:13 Md. R. 990)

Regulation .07 amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .07 amended effective February 16, 2004 (31:3 Md. R. 207)

Regulation .07 amended as an emergency provision effective July 16, 2009 (36:17 Md. R. 1310); amended permanently effective October 5, 2009 (36:20 Md. R. 1527)

Regulation .07 amended effective November 28, 2011 (38:24 Md. R. 1502); March 18, 2013 (40:5 Md. R. 411); December 12, 2013 (40:24 Md. R. 2016); December 11, 2014 (41:24 Md. R. 1427)

Regulation .07A amended effective June 25, 1990 (17:12 Md. R. 1494)

Regulation .07A-2 adopted effective February 12, 2007 (34:3 Md. R. 297)

Regulation .07A-2 amended as an emergency provision effective July 1, 2007 (34:15 Md. R. 1345); emergency status extended at 35:3 Md. R. 286; emergency status expired June 24, 2008

Regulation .07A-2, C amended as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .07A-2, C amended effective September 22, 2008 (35:19 Md. R. 1716)

Regulation .07A-3 adopted effective September 22, 2008 (35:19 Md. R. 1716)

Regulation .07A-3 amended effective April 6, 2009 (36:7 Md. R. 523)

Regulation .07A-4 adopted effective April 6, 2009 (36:7 Md. R. 523)

Regulation .07B amended effective February 12, 2007 (34:3 Md. R. 297)

Regulation .07C amended effective March 19, 1990 (17:5 Md. R. 638)

Regulation .07C-1 amended effective April 5, 2010 (37:7 Md. R. 570)

Regulation .07C-2 and C-3 adopted effective April 5, 2010 (37:7 Md. R. 570)

Regulation .07C-4 adopted effective December 27, 2010 (37:26 Md. R. 1787)

Regulation .07-1 adopted as an emergency provision effective May 1, 2004 (31:12 Md. R. 908); adopted permanently effective August 16, 2004 (31:16 Md. R. 1255)

Regulation .07-1F, I amended effective April 10, 2006 (33:7 Md. R. 668); August 27, 2007 (34:17 Md. R. 1508); September 22, 2008 (35:19 Md. R. 1716)

Regulation .07-1I amended as an emergency provision effective July 16, 2009 (36:17 Md. R. 1310); amended permanently effective October 5, 2009 (36:20 Md. R. 1527)

Regulation .07-1I amended effective January 24, 2011 (38:2 Md. R. 84); October 3, 2011 (38:20 Md. R. 1202); February 18, 2013 (40:3 Md. R. 218); February 3, 2014 (41:2 Md. R. 91); December 11, 2014 (41:24 Md. R. 1427)

Regulations .08—.11-1, .17, .20, and .21 amended as an emergency provision effective July 1, 1996 (23:15 Md. R. 1081); amended permanently effective November 4, 1996 (23:22 Md. R. 1496)

Regulations .08—.11 amended as an emergency provision effective July 1, 1997 (24:16 Md. R. 1149) (Emergency provisions are temporary and not printed in COMAR)

Regulations .08—.11 amended as an emergency provision effective July 1, 1998 (25:15 Md. R. 1181); amended permanently effective October 19, 1998 (25:21 Md. R. 1574)

Regulations .08—.11, .13, and .16 amended as an emergency provision effective July 1, 1999 (26:16 Md. R. 1237 and 26:18 Md. R. 1369); emergency status expired September 30, 1999

Regulation .08 amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .08 amended effective February 16, 2004 (31:3 Md. R. 207); September 22, 2008 (35:19 Md. R. 1716); March 18, 2013 (40:5 Md. R. 411)

Regulation .08B amended effective July 1, 1993 (20:12 Md. R. 996); October 20, 1997 (24:21 Md. R. 1449); December 9, 2005 (32:24 Md. R. 1904)

Regulation .08B, E amended as an emergency provision effective July 1, 2007 (34:15 Md. R. 1345); emergency status extended at 35:3 Md. R. 286; emergency status expired June 24, 2008

Regulation .08B, E amended as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .08B, E amended effective April 6, 2009 (36:7 Md. R. 523); December 27, 2010 (37:26 Md. R. 1787); November 28, 2011 (38:24 Md. R. 1502); December 12, 2013 (40:24 Md. R. 2016)

Regulation .08B, E, H amended effective September 22, 2008 (35:19 Md. R. 1716)

Regulation .08E amended effective July 1, 1993 (20:12 Md. R. 996); June 6, 1994 (21:11 Md. R. 951); November 7, 1994 (21:22 Md. R. 1876); October 20, 1997 (24:21 Md. R. 1449); December 9, 2005 (32:24 Md. R. 1904)

Regulations .08E, .09E, and .10L amended as an emergency provision effective January 6, 1994 (21:2 Md. R. 95); emergency status extended at 21:9 Md. R. 744; emergency status expired June 5, 1994

Regulations .08E, .09E, and .10L amended as an emergency provision effective July 1, 1994 (21:16 Md. R. 1379); emergency status expired November 7, 1994

Regulation .08H adopted effective September 11, 2006 (33:18 Md. R. 1505)

Regulation .08H repealed as an emergency provision effective July 1, 2007 (34:15 Md. R. 1345); emergency status extended at 35:3 Md. R. 286; emergency status expired June 24, 2008

Regulation .08H repealed as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .09B amended effective July 1, 1993 (20:12 Md. R. 996); October 20, 1997 (24:21 Md. R. 1449)

Regulation .09E amended effective July 1, 1993 (20:12 Md. R. 996); June 6, 1994 (21:11 Md. R. 951); November 7, 1994 (21:22 Md. R. 1876); October 20, 1997 (24:21 Md. R. 1449)

Regulation .09E amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .09E amended effective February 16, 2004 (31:3 Md. R. 207); December 9, 2005 (32:24 Md. R. 1904)

Regulation .09E amended as an emergency provision effective July 1, 2007 (34:15 Md. R. 1345); emergency status extended at 35:3 Md. R. 286; emergency status expired June 24, 2008

Regulation .09E amended as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .09E amended effective April 6, 2009 (36:7 Md. R. 523); December 27, 2010 (37:26 Md. R. 1787); November 28, 2011 (38:24 Md. R. 1502)

Regulation .09E, F amended effective March 18, 2013 (40:5 Md. R. 411)

Regulation .09E, H amended effective September 22, 2008 35:19 Md. R. 1716)

Regulation .09H adopted effective September 11, 2006 (33:18 Md. R. 1505)

Regulation .09H repealed as an emergency provision effective July 1, 2007 (34:15 Md. R. 1345); emergency status extended at 35:3 Md. R. 286

Regulation .09H repealed as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .10 amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .10 amended effective February 16, 2004 (31:3 Md. R. 207)

Regulation .10C amended effective September 20, 2010 (37:19 Md. R. 1283)

Regulation .10G amended effective December 9, 2005 (32:24 Md. R. 1904)

Regulation .10G amended as an emergency provision effective July 1, 2007 (34:15 Md. R. 1345); emergency status extended at 35:3 Md. R. 286; emergency status expired June 24, 2008

Regulation .10G amended as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .10G amended effective September 22, 2008 35:19 Md. R. 1716); April 6, 2009 (36:7 Md. R. 523); December 27, 2010 (37:26 Md. R. 1787); November 28, 2011 (38:24 Md. R. 1502); March 18, 2013 (40:5 Md. R. 411); December 12, 2013 (40:24 Md. R. 2016)

Regulation .10I amended as an emergency provision effective July 1, 2001 (28:16 Md. R. 1480); amended permanently effective October 1, 2001 (28:19 Md. R. 1684)

Regulation .10L amended effective July 1, 1993 (20:12 Md. R. 996); June 6, 1994 (21:11 Md. R. 951); November 7, 1994 (21:22 Md. R. 1876); October 20, 1997 (24:21 Md. R. 1449)

Regulation .10N adopted as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .10N adopted effective September 22, 2008 35:19 Md. R. 1716)

Regulation .11 amended as an emergency provision effective July 1, 2001 (28:16 Md. R. 1480); amended permanently effective October 1, 2001 (28:19 Md. R. 1684)

Regulation .11 amended effective July 8, 2002 (29:13 Md. R. 990)

Regulation .11 amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003; March 18, 2013 (40:5 Md. R. 411)

Regulation .11 amended effective February 16, 2004 (31:3 Md. R. 207)

Regulation .11C amended effective July 1, 1993 (20:12 Md. R. 996)

Regulation .11C amended as an emergency provision effective January 6, 1994 (21:2 Md. R. 95); emergency status extended at 21:9 Md. R. 744 and 21:16 Md. R. 1379; emergency status expired August 14, 1994

Regulation .11C amended effective August 15, 1994 (21:16 Md. R. 1383); November 7, 1994 (21:22 Md. R. 1876); October 20, 1997 (24:21 Md. R. 1449); December 9, 2005 (32:24 Md. R. 1904)

Regulation .11C amended as an emergency provision effective July 1, 2007 (34:15 Md. R. 1345); emergency status extended at 35:3 Md. R. 286; emergency status expired June 24, 2008

Regulation .11C amended as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .11C amended effective September 22, 2008 35:19 Md. R. 1716); April 6, 2009 (36:7 Md. R. 523); December 27, 2010 (37:26 Md. R. 1787); December 12, 2013 (40:24 Md. R. 2016)

Regulation .11G amended effective August 15, 1994 (21:16 Md. R. 1383); October 20, 1997 (24:21 Md. R. 1449); December 9, 2005 (32:24 Md. R. 1904); April 5, 2010 (37:7 Md. R. 570); December 12, 2013 (40:24 Md. R. 2016)

Regulation .11U adopted effective August 15, 1994 (21:16 Md. R. 1383)

Regulation .11U adopted as an emergency provision effective April 1, 2008 (35:9 Md. R. 892; emergency status expired September 3, 2008

Regulation .11U adopted effective September 22, 2008 35:19 Md. R. 1716)

Regulation .11-1 adopted as an emergency provision effective January 6, 1994 (21:2 Md. R. 96); adopted permanently effective May 1, 1994 (21:7 Md. R. 530)

Regulation .11-1 repealed as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .11-1 repealed effective February 16, 2004 (31:3 Md. R. 207)

Regulations .11-1—.11-6 adopted effective January 24, 2011 (38:2 Md. R. 84)

Regulation .11-1A amended effective November 28, 2011 (38:24 Md. R. 1502)

Regulation .11-2E amended effective November 28, 2011 (38:24 Md. R. 1502)

Regulation .12A amended effective February 12, 2007 (34:3 Md. R. 297)

Regulation .13 amended effective March 19, 1990 (17:5 Md. R. 638)

Regulation .13E amended as an emergency provision effective July 1, 2001 (28:16 Md. R. 1480); amended permanently effective October 1, 2001 (28:19 Md. R. 1684)

Regulation .13I amended as an emergency provision effective January 28, 1991 (18:3 Md. R. 301); emergency status expired April 8, 1991 (18:9 Md. R. 1004)

Regulation .13I amended as an emergency provision effective April 9, 1991 (18:9 Md. R. 1005); amended permanently effective October 7, 1991 (18:18 Md. R. 2004)

Regulation .13L adopted effective August 15, 1994 (21:16 Md. R. 1383)

Regulation .13P adopted as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .13P adopted effective September 22, 2008 35:19 Md. R. 1716)

Regulation .14 amended effective June 6, 1994 (21:11 Md. R. 951)

Regulation .14C-1 adopted as an emergency provision effective July 1, 2001 (28:16 Md. R. 1480); adopted permanently effective October 1, 2001 (28:19 Md. R. 1684)

Regulation .14G amended effective March 19, 1990 (17:5 Md. R. 638)

Regulation .15 amended effective March 19, 1990 (17:5 Md. R. 638); October 3, 2011 (38:20 Md. R. 1202)

Regulation .15A amended effective March 17, 2003 (30:5 Md. R. 366)

Regulation .15B amended as an emergency provision effective May 1, 2004 (31:12 Md. R. 908); amended permanently effective August 16, 2004 (31:16 Md. R. 1255)

Regulation .16 amended effective February 19, 1990 (17:3 Md. R. 297); December 29, 1997 (24:26 Md. R. 1758); July 8, 2002 (29:13 Md. R. 990); March 18, 2013 (40:5 Md. R. 411)

Regulation .16D amended effective April 5, 2010 (37:7 Md. R. 570)

Regulations .16E and G. and .17J amended and .17K adopted as an emergency provision effective April 4, 1991 (18:9 Md. R. 1004); adopted permanently effective July 22, 1991 (18:14 Md. R. 1609)

Regulations .16E and G amended and .30 adopted as an emergency provision effective January 1, 1991 (18:2 Md. R. 146); emergency status expired April 8, 1991 (18:9 Md. R. 1005)

Regulation .16E amended effective September 27, 2004 (31:19 Md. R. 1432); October 14, 2013 (40:20 Md. R. 1652)

Regulation .16F amended effective March 17, 2003 (30:5 Md. R. 366)

Regulation .16F amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .16F amended effective February 16, 2004 (31:3 Md. R. 207); December 9, 2005 (32:24 Md. R. 1904); April 6, 2009 (36:7 Md. R. 523); December 27, 2010 (37:26 Md. R. 1787); November 28, 2011 (38:24 Md. R. 1502)

Regulation .16G amended effective June 3, 1996 (23:11 Md. R. 810)

Regulation .17 amended effective July 8, 2002 (29:13 Md. R. 990); May 9, 2005 (32:9 Md. R. 848); December 9, 2005 (32:24 Md. R. 1904); March 18, 2013 (40:5 Md. R. 411); December 11, 2014 (41:24 Md. R. 1427)

Regulation .17K amended and L—O adopted effective June 6, 1994 (21:11 Md. R. 951)

Regulation .18A amended effective March 18, 2013 (40:5 Md. R. 411)

Regulations .20—.23 amended as an emergency provision effective January 6, 1994 (21:2 Md. R. 96); adopted permanently effective May 1, 1994 (21:7 Md. R. 531)

Regulation .20 amended as an emergency provision effective July 1, 1998 (25:15 Md. R. 1181); amended permanently effective October 19, 1998 (25:21 Md. R. 1574)

Regulation .20 amended effective December 9, 2005 (32:24 Md. R. 1904)

Regulation .21 amended effective December 9, 2005 (32:24 Md. R. 1904)

Regulation .22 amended as an emergency provision effective April 1, 2008 (35:9 Md. R. 892); emergency status expired September 3, 2008

Regulation .22 amended effective September 22, 2008 35:19 Md. R. 1716)

Regulation .23 amended effective December 9, 2005 (32:24 Md. R. 1904)

Regulation .24A, B amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .24A, B amended effective February 16, 2004 (31:3 Md. R. 207); March 18, 2013 (40:5 Md. R. 411)

Regulation .25B amended effective August 15, 1994 (21:16 Md. R. 1383); February 16, 2004 (31:3 Md. R. 207); February 12, 2007 (34:3 Md. R. 297); March 18, 2013 (40:5 Md. R. 411)

Regulation .25C amended as an emergency provision effective July 1, 2003 (30:15 Md. R. 990); emergency status expired December 31, 2003

Regulation .27A amended effective June 6, 1994 (21:11 Md. R. 951)

Regulation .27A-1 adopted as an emergency provision effective October 16, 1995 (22:22 Md. R. 1654); adopted permanently effective January 15, 1996 (23:1 Md. R. 25)

Regulation .27C amended effective December 29, 1997 (24:26 Md. R. 1758)

Regulation .28 amended effective January 24, 2011 (38:2 Md. R. 84)

Regulation .30 adopted effective May 9, 2005 (32:9 Md. R. 848)

Chapter revised effective April 13, 2015 (42:7 Md. R. 567)

Regulation .07-1I amended effective December 19, 2016 (43:25 Md. R. 1384); January 1, 2018 (44:26 Md. R. 1214)

Regulation .07-2 amended effective February 29, 2016 (43:4 Md. R. 331)

Regulation .07-2L, M adopted effective December 19, 2016 (43:25 Md. R. 1384)

Regulation .07-2N adopted effective January 1, 2018 (44:26 Md. R. 1214)

Regulation .10-1B amended effective February 29, 2016 (43:4 Md. R. 331); December 19, 2016 (43:25 Md. R. 1384)

Regulation .11-2B amended effective December 19, 2016 (43:25 Md. R. 1384)

Regulation .11-7C amended effective December 19, 2016 (43:25 Md. R. 1384)

Regulation .11-8C amended effective December 19, 2016 (43:25 Md. R. 1384)

Regulation .12-1A, B amended effective February 29, 2016 (43:4 Md. R. 331)

Regulation .13O amended effective February 29, 2016 (43:4 Md. R. 331)

Regulation .15-1 amended effective February 29, 2016 (43:4 Md. R. 331)

Regulation .15-1D amended effective December 19, 2016 (43:25 Md. R. 1384)

Regulation .16-1G amended effective February 29, 2016 (43:4 Md. R. 331)

Regulation .16-1I adopted effective February 29, 2016 (43:4 Md. R. 331)

Regulation .25C adopted effective December 19, 2016 (43:25 Md. R. 1384)

Regulation .28B amended effective February 29, 2016 (43:4 Md. R. 331)

Chapter revised effective July 2, 2018 (45:13 Md. R. 664)

Regulation .01B amended effective June 14, 2021 (48:12 Md. R. 472)

Regulation .07G amended effective May 20, 2019 (46:10 Md. R. 486); December 30, 2019 (46:26 Md. R. 1164)

Regulation .08H amended effective May 20, 2019 (46:10 Md. R. 486); December 30, 2019 (46:26 Md. R. 1164); June 14, 2021 (48:12 Md. R. 472)

Regulation .11B amended effective May 20, 2019 (46:10 Md. R. 486)

Regulation .13A amended effective May 20, 2019 (46:10 Md. R. 486)

Regulation .15 amended effective June 14, 2021 (48:12 Md. R. 472)

Regulation .19 amended effective June 14, 2021 (48:12 Md. R. 472)

Regulation .30 amended effective December 30, 2019 (46:26 Md. R. 1164)