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Attachments to Section 4

Attachment 4.14 A

Reserved for Future Use

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Attachment 4.14 C

Reserved for Future Use

TN # 11-05
Supersedes TN # 85-06

Approval Date AUG 8 2011 Effective Date APRIL 1, 2011

COOPERATIVE AGREEMENT
Between
STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAMS
and
STATE DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
for
STATE OF MARYLAND

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planatory WHEREAS, the Medical Assistance Program, State Department of Health and Mental Hygiene (hereinafter "the Program") is established pursuant to 42 U.S.C. §1396 et seq., and Article 43, §42, Annotated Code of Maryland, for the purpose of providing comprehensive health care services to certain eligible indigent and medically indigent residents of the State of Maryland, and

WHEREAS, the Division of Vocational Rehabilitation of the State Department of Education (hereinafter "the Division") is established, pursuant to Education Article, Title 21, §21-301 through 404, Annotated Code of Maryland, as the official state agency in Maryland for the provision of services necessary to enable vocationally handicapped individuals to engage in gainful employment, and

WHEREAS, there are many individuals residing in the State of Maryland who are eligible for the benefits of both programs;

THEREFORE, this Cooperative Agreement is entered into between the Program and the Division in order to establish the means for practical working relationships between the two agencies for the purpose of providing maximum medical and rehabilitative services to the handicapped residents of the State of Maryland.

In consequence of the foregoing, the parties hereto mutually agree to the following:

1. The Program will provide the first dollar whenever medical services are provided to eligible persons of the Program and of the Division.

2. That when the Division has a client who may be eligible for Medical Assistance benefits, that client will be referred to his or her local Department of Social

SEP 15 1981

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SA Approved

Services to make application for such benefits.

3. That the Division will refer its clients who are also eligible for Medical Assistance benefits to providers of service who are participating in the Medical Assistance Program.

4. That the Division, through its local departments, will encourage Medical Assistance - eligible clients under the age of 21 to seek preventive health care services available under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program from providers certified by the Program to provide EPSDT services.

5. That the Program will make payment to such providers, at its established rates, for services covered by the Program and rendered to eligible individuals.

Prohibitions
on
Additional
Payments

6. That when the Program makes payment to a provider for a covered service, no additional payment for such service may be received by the provider from the eligible individual or from any other source, except for such recoveries as may be allowed pursuant to the regulations and guidelines of the Program (eligible individuals may contribute \$.50 to the cost of pharmaceutical products).

7. That the Program will keep the Division apprised, at all times, of those services which are available, pursuant to the Programs's regulations and guidelines, to eligible individuals.

Confiden-
tiality

8. That the Division will maintain the confidentiality, pursuant to Section 1902(a)(7) of the Social Security Act, 42 U.S.C., §1396 et seq., 45 C.F.R. §250.80(a)(6), and Article 43, §II, Annotated Code of Maryland, of the names and medical records of Medical Assistance recipients, and will not disclose such information except for purposes directly connected with the administration of the Medical Assistance Program. However, the Division may release information when the client requests in writing that his/her information be released to another party.

Liaison

9. That at all times during which this Agreement is in effect, each party hereto shall have appointed a Liaison Officer, and that for the original period of this Agreement, those Liaison Officers shall be, for the Program, Henry E. Schwartz, Special Attorney, and for the Division, Fredric G. Antenberg, Staff Specialist for Sheltered Workshops and Rehabilitation Facilities.

By Ind _____
HO Approved 10/28/81 Effective 7/1/81
SEP 16 1981

10. That the responsibilities of said Liaison Officers shall include:

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a. Keeping the other party apprised of planned or impending policy changes

b. Working with the other party to develop policy changes in such a way as to plan for the needs of the clients of both agencies

c. Working with the other party to implement policy changes in such a manner as to account for the needs of the clients of both agencies

d. To be available for consultation by the other party whenever there arises a problem in the relationship of the agencies, or whenever either party requires an explanation of policies or procedures of the other agency

e. To review this Cooperative Agreement each year, or sooner if there arise any problems in its operation, for the purpose of determining whether the existing Agreement requires modification in order to fully effectuate the intention of the parties as stated above.

11. That the terms of this Cooperative Agreement shall be in effect from April 16, 1979 until April 15, 1980, and that this Agreement shall subsequently be automatically renewed for successive one-year periods, unless 60 days notice is given by either party prior to the expiration of the Agreement.

12. That this Cooperative Agreement may be terminated by either party, at any time, upon 60 day notice given to the other party.

Agreed by:

Charles C. Putnam May 29, 1979
Charles C. Putnam, Director Date
Medical Assistance Program

John M. Cobun
John M. Cobun, Assistant State Date
Superintendent in Vocational
Rehabilitation

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

THIS 28th Day of May 1979

1. Md SA Approved
RO Approved 10/28/81 Effective 7/1/81
SEP 16 1981

Stephen J. Spikas
STEPHEN J. SPIKAS
Assistant Attorney General

COOPERATIVE AGREEMENT
Between
MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
TITLE XIX MEDICAID AGENCY,
TITLE V MATERNAL AND CHILD HEALTH AGENCY,
TITLE X FAMILY PLANNING PROGRAM, AND THE
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS
AND CHILDREN (WIC)

WHEREAS, the Maryland Medical Assistance Program, Maryland Department of Health and Mental Hygiene (hereinafter "the Medicaid Program") is established pursuant to Title XIX of the Social Security Act of 1935, 42 U.S.C. §1396 et seq., and Health – General Article, §15-101 et seq., Annotated Code of Maryland for the purpose of providing comprehensive health care services to certain eligible low-income residents of the State of Maryland including Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) services; and

WHEREAS, the Children's Health Insurance Program is established pursuant to Title XXI of the Social Security Act of 1935, 42 U.S.C. §1397 et seq., and in Maryland is known as the Maryland Children's Health Program pursuant to Health – General Article, §15-301 et seq., Annotated Code of Maryland for the purpose of providing comprehensive health care services to certain eligible low-income children under age 19 who are not otherwise eligible for Medicaid; and

WHEREAS, the Medicaid Program also operates the Maryland Children's Health Program as a Medicaid expansion with full Medicaid benefits and herein will also be referred to as the Medicaid Program; and

WHEREAS, the Medicaid Program is responsible for outreaching and informing all EPSDT eligible individuals about the importance of preventive health care, the Healthy Kids Program and Expanded EPSDT services, and the WIC Program; and

WHEREAS, the Medicaid Program is responsible for the daily operations of the Maternal and Child Health 800-line for the State of Maryland, and the Prevention and Public Health Administration's Maternal and Child Health Program will provide staff upon request at high volume times such as mass media campaigns; and

WHEREAS, the Medicaid Program is responsible for payment for Medicaid services delivered to Medicaid beneficiaries by Title V and Title X providers; and

WHEREAS, the Prevention and Health Promotion Administration (hereinafter "PHPA") oversees the Title V Maternal and Child Health Agency and is responsible for the utilization of funds provided by the Maternal and Child Health Block Grant of Title V of the Social Security Act of 1935, 42 U.S.C. §701 et seq., and Health – General Article, §18-107, Annotated Code of Maryland in the provision of maternal and child health services and services for children with special health care needs; and

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WHEREAS, PHPA plays a key role in identifying pregnant women, infants, and children who are eligible for the Medicaid Program and, once identified, assisting them in applying for such assistance; and

WHEREAS, PHPA, often through its local health department designees, provides the infrastructure for health care programs which may be utilized to provide services to the Medicaid Program's beneficiaries; and

WHEREAS, PHPA is responsible for Statewide needs assessment, program planning, development, implementation, and evaluation of maternal and child health programs; and

WHEREAS, PHPA is responsible for providing funding for clinical services for low-income maternal and child health populations not eligible for Medicaid; and

WHEREAS, PHPA is responsible for assuring access to specialty care for children with special health care needs; and

WHEREAS, a medical home is of utmost importance for all children to assure early identification and treatment of health problems; and

WHEREAS, PHPA oversees the Special Supplemental Nutrition Program for Women, Infants and Children, Maryland Department of Health and Mental Hygiene (hereinafter "the WIC Program") and is established pursuant to §17 of the Child Nutrition Act of 1966, 42 U.S.C. §1786 et seq., and Health-General Article, §18-108, Annotated Code of Maryland for the purpose of providing supplemental foods and nutrition education to pregnant and postpartum women, infants and young children from families with low incomes who are at risk by reason of inadequate nutrition or health care, or both; and

WHEREAS, the WIC Program, administered by PHPA through its local agencies, is responsible for ensuring that high-risk populations who are potentially eligible for WIC are identified and made aware of the Program's benefits and services; and

WHEREAS, the WIC Program serves as an adjunct to good health care during critical times of growth and development; and

WHEREAS, the WIC Program is responsible for certifying eligible applicants, informing applicants of the health services which are available, making referrals to appropriate health services, providing nutrition education to participants, and employing a voucher system to make WIC foods available to participants at no cost to eligible persons; and

WHEREAS, PHPA also administers the Family Planning Program under Title X of the Public Health Services Act of 1970, 42 U.S.C. §300 et seq.; and

WHEREAS, PHPA has responsibility for Statewide needs assessment, program planning, development, implementation, service delivery, and quality assurance of the Statewide family

planning program, including oversight for services provided by local health department and other delegate agencies; and

WHEREAS, family planning is a key strategy for improving maternal and child health (MCH) outcomes; and

WHEREAS, together Medicaid and PHPA MCH-related programs have the capacity to reduce maternal and infant mortality and childhood morbidity and mortality, promote the health of mothers, infants, and children, and reduce disparities in health outcomes due to race;

THEREFORE, this Cooperative Agreement is entered into between the Medicaid Program and the Prevention and Public Health Administration in order to establish roles and responsibilities between the parties for the purpose of providing coordination of services to promote prompt access to high-quality prenatal, intrapartum, postpartum, postnatal and child health services for women and children eligible for benefits under Titles V, XIX, and XXI of the Social Security Act, as amended, Title X of the Public Health Services Act of 1970, as amended, and §17 of the Child Nutrition Act of 1966, as amended.

In recognition of the foregoing, the Medicaid Program and the Prevention and Public Health Administration, representing the Title V Program, the WIC Program, and the Title X program, mutually agree to the following:

I. ADMINISTRATION AND POLICY

1. All services will be provided without regard to race, creed, color, age, sex, national origin, marital status, or physical or mental handicap.
2. The Medicaid Program will establish Medicaid eligibility policy, regulations and procedures which facilitate access to care for pregnant women and children.
3. PHPA programs and their local health department designees will refer its clients who are eligible for Medicaid benefits and assist them in receiving services from providers who participate in the Maryland Medical Assistance Program.
4. PHPA will provide Medicaid with clinical and programmatic consultation and technical assistance related to programs and policies for pregnant women, infants, and children, including children with special health care needs.
5. All parties will coordinate activities to enhance customer service and work to resolve problems which impact on timely access to services.
6. All parties will coordinate strategic planning efforts to assure coordination in the design, implementation and evaluation of program services for women, infants and children, including children with special health care needs.

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7. All parties will keep each other apprised of those services which are available to eligible individuals pursuant to federal law and State regulations and guidelines.
8. All parties will collaborate when implementing significant changes to program policies that may impact the other (i.e. policy, regulations, budget priorities, operational or compliance changes).
9. All parties will develop program policies and regulations that address standards of quality care.
10. All parties will promote family planning and prenatal care as key strategies for improving MCH outcomes.
11. All parties will promote the importance of a family centered medical and dental home for all children and encourage early identification and treatment.
12. PHPA and Medicaid will collaborate on the development of tools and processes for identifying high-risk pregnant women and will jointly provide support for the Maryland Prenatal Risk Assessment system.
13. PHPA and Medicaid will collaborate in developing training and education programs for medical professionals and consumers to benefit maternal and child health populations.
14. PHPA and Medicaid will notify each other of policy or procedural changes that may affect access to services and will coordinate on initiatives to improve maternal and child health.
15. PHPA will coordinate with Medicaid regarding childhood health promotion and prevention programs, such as obesity, asthma, and lead poisoning activities and programs.
16. Program Directors within PHPA and Medicaid further agree to designate from their staffs appropriate liaisons whose responsibilities shall include regular and periodic communication about the programs and operations described in this Cooperative Agreement.
17. The designated liaison staff from Medicaid and PHPA will meet on a quarterly basis to share developments within the programs and to plan/coordinate new and on-going activities.

II. REIMBURSEMENT & CONTRACT MONITORING

18. PHPA and its local health department designees will assure that medical services are furnished by or under the direction of a physician and that dental services are furnished by or under the direction of a dentist.

19. PHPA and its local health department designees will maintain adequate medical and financial records for a minimum of six years in a manner prescribed by the Medicaid Program and provide them to the Medicaid Program upon request.
20. PHPA and its designees will not employ or contract with a person, partnership or corporation which has been disqualified from the Medicaid Program to provide or supply services to the Title XIX recipients unless prior written approval has been received from Medicaid.
21. Medicaid and PHPA will collaborate to determine the best methodology for reimbursing Title V and Title X providers taking into consideration the cost of providing such services and the need to assure access to care.
22. When Medicaid makes payment to a Title V or Title X designee for a covered service, the Title V or Title X designee (e.g., local health department) will not require additional payment from the Medicaid recipient. If Medicaid denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or preauthorized if required by regulation, the Title V Agency will not seek payment from the Medicaid recipient for that service.
23. If an individual is eligible for services covered by both Medicaid/Title XIX and Title V or Title X programs, Title XIX funds will be utilized to reimburse providers for services covered by the Program. When a Medicaid recipient has other health insurance or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the recipient for services covered by Medicaid, the Title V and Title X programs agree to seek payment from that source first. If payment is made by both Medicaid and the insurance or other source, the Title V Agency shall refund the Medicaid payment, within sixty days of receipt, the amount reimbursed by Medicaid or the amount paid by the insurance or other source, whichever is less.
24. All parties will assure that services provided by its grantees are not duplicative and that services are consistent with Medicaid policies and the federal regulations and policies governing the Title V and Title X programs.
25. PHPA will collaborate with Medicaid regarding the planning and implementation of publicly funded State initiatives such as oral health, family planning initiatives, and infant mortality prevention.
26. PHPA and Medicaid will maintain a system to assure coverage for special infant formulas.
27. PHPA will provide specialty services for children with special health care needs that are not covered by Medicaid within limitations imposed by regulations and budgetary constraints.

III. DATA EXCHANGE

28. Medicaid and PHPA shall share data and participate in joint planning efforts in order to identify service gaps and improve the delivery of services to low-income pregnant women and children, including children with special health care needs and in accordance with federal regulations and guidelines.
29. All parties will assure that any sharing of client data conforms to privacy and confidentiality rules in accordance with state and federal regulations, and will safeguard and maintain the confidentiality of the names and medical records of recipients.
30. Medicaid will provide PHPA with access to select Medicaid data files to accomplish public health surveillance as permitted by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191). PHPA will maintain the confidentiality of the names and medical records of Medicaid recipients. Such information may be released to a third party, other than another treating provider, only in accordance with HIPAA.
31. PHPA and Medicaid will participate in the exchange of data necessary for annual federal grant applications, and federal or State required reporting including:
 - a. Title V MCH Block Grant National and State Performance Measures;
 - b. Title V State Performance Measure benchmarks for data systems and sharing;
 - c. Periodic Title V-MCH and Title X-Family Planning Needs Assessments;
 - d. Title X Family Planning Annual Report (FPAR);
 - e. Title V-Section 511 Maternal, Infant, and Early Childhood Home Visiting Program; and
 - f. Title V-Section 513 Personal Responsibility and Education Program.
32. Medicaid and PHPA programs will also coordinate and participate in the exchange of data related to ongoing program operations including:
 - a. Medicaid eligibility and enrollment of pregnant women and birth outcomes for these clients;
 - b. Medicaid Prenatal Risk Assessment;
 - c. Utilization of family planning services by women eligible enrolled in the current Medicaid waiver or utilization of family planning services by eligible women under any future Medicaid expansion of family planning eligibility;
 - d. Utilization of Title X family planning services by Medicaid and WIC recipients;
 - e. Utilization of oral health services by Medicaid recipients;
 - f. Fetal, infant, and child death reviews;
 - g. Surveillance data on children screening for blood lead levels and those with elevated blood lead levels;
 - h. Surveillance data on childhood developmental and mental health screening;
 - i. Surveillance data on child and adult asthma and related respiratory illnesses;
 - j. Surveillance data on childhood obesity;
 - k. Utilization of specialty services by Medicaid-eligible Children with Special Health Care Needs Program; and

1. Access to data to assure a continued high survey response rate for the Pregnancy Risk Assessment Monitoring System (PRAMS).
33. Medicaid and PHPA will exchange data necessary to conduct utilization studies to assess the impact of the Maryland Dent-Care Loan Assistance Repayment Program.

The remainder of this cooperative agreement addresses more specific recipient outreach and referral, training and technical assistance, provider capacity, and quality assurance activities to be carried out by Medicaid and by specific programs conducted by PHPA.

IV. OUTREACH AND REFERRAL ACTIVITIES

A. All MCH Populations

1. All PHPA programs will assist Medicaid in distributing information on how to apply for Medicaid and will direct potentially eligible families to the Maryland Health Connection.
2. All PHPA programs will assist Medicaid in efforts to encourage Medicaid beneficiaries to renew their eligibility annually.
3. All PHPA programs will verify a client's Medicaid eligibility prior to providing service.
4. Medicaid, through its local health department (LHD) grantees, will conduct outreach to Medicaid recipients to assure that families are informed about EPSDT services, WIC, and relevant Title V and Title X programs.
5. Medicaid and PHPA programs will coordinate hotline activities to share information and assure that callers are referred to the appropriate services.

B. Primary Preventive Care for Children and Oral Health

1. Medicaid will perform outreach to encourage low-income maternal and child populations to apply for Medicaid and to utilize preventive and primary medical and dental care services.
2. Oral Health will refer children in need of oral health services who are identified through publicly funded oral health programs conducted in schools, Head Start, WIC centers, etc. to the appropriate private or public health dental provider for treatment.
3. Oral Health and Medicaid will work collaboratively to update the resource guide of public health dental programs serving low-income and uninsured populations.
4. Oral Health will collaborate with Medicaid to educate parents and pregnant women on the importance of oral health.

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Supersedes: 10-10

Approval Date: February 16, 2016

Effective Date: October 1, 2015

C. Children With Special Health Care Needs

1. CSHCN will provide statewide resource and referral services to families and providers of children with special health care needs.
2. Medicaid will refer those children with special health care needs that are not eligible for Medicaid to PHPA for assistance with resources and services.
3. Medicaid will link families of children with special health care needs to the CSHCN or community resources for services not generally covered by Medicaid.
4. CSHCN will refer Medicaid children in need of special assistance or care coordination to the appropriate Medicaid case manager.
5. CSHCN will follow-up with the families of all infants who missed or did not pass the newborn hearing screens.
6. Medicaid will assist families in accessing specialty care services and navigating the health care delivery system.

D. Pregnant Women and Infants

1. MCH will assure a local point of entry for all uninsured/underinsured pregnant women and will link these women with providers willing to serve patients on a sliding scale basis.
2. MCH and Medicaid will collaborate on strategies to increase the number of pregnant women initiating prenatal care in the first trimester of pregnancy.
3. MCH, Oral Health and Medicaid will collaborate on strategies to increase the number of pregnant women receiving dental care during pregnancy.

E. Family Planning

1. MCH/Family Planning (FP) and Medicaid will collaborate on strategies to increase utilization of family planning services, especially among women enrolled in managed care and the Medicaid Family Planning Waiver.
2. Medicaid and FP will collaborate and coordinate the dissemination of information about family planning for the public and for potential Medicaid recipients and Title X-family planning program clients, including the development of brochures and other outreach materials, information posted on Medicaid and PHPA websites, etc.
3. Medicaid will assure that eligible women whose Medicaid pregnancy-related benefits have ended are enrolled in the Medicaid Family Planning waiver.

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4. MCH/FP will serve Medicaid clients who chose a Title V or Title X provider for family planning services under the “Freedom of Choice” for provision of the Medicaid Program for family planning services and bill Medicaid or Managed Care Organizations as indicated by eligibility category.
5. MCH/FP programs will refer Medicaid Family Planning waiver clients to primary care providers for services provided on a sliding scale basis.
6. Medicaid will refer women who lose family planning waiver eligibility to Title X family planning services which are provided to self-pay/uninsured or underinsured individuals on a sliding fee scale and are provided regardless of ability to pay.

F. WIC

1. Medicaid, through its grantees, hotlines, and managed care providers, will refer pregnant and postpartum women, infants and children to WIC.
2. WIC will accept verification of Medicaid eligibility as proof of financial eligibility for WIC services.
3. WIC and Medicaid will refer families to Title V, Title X services and other health-related and social services for mothers, infants, and children including children with special health care needs.
4. WIC, MCH, FP and Medicaid will identify outreach networks, distribute literature and perform targeted community outreach publicizing WIC program availability.
5. WIC and Medicaid will coordinate to assure that information about the WIC program is available in areas where Medicaid/Maryland Children’s Health Program (MCHP) applications are processed.
6. CSHCN and Medicaid will collaborate to improve referrals and access to WIC services for children with special health care needs.

V. TRAINING AND TECHNICAL ASSISTANCE

A. All MCH Programs

1. Medicaid will train LHD eligibility staff in the processing of Medicaid applications for potentially eligible pregnant women, children and families.
2. Medicaid and PHPA will collaborate on the production of outreach materials to be used by PHPA programs, Medicaid, providers and staff to assure that information regarding how to apply for Medicaid/MCHP is included.
3. Medicaid will provide training and technical support to LHD grantees related to Medicaid administrative functions, including outreach and care coordination.

4. PHPA programs and Medicaid will collaborate to provide training, consultation and technical assistance to Medicaid, Title V and Title X providers in the delivery of home visiting and case management services.

B. Primary Preventive Pediatric Medical and Dental Providers

1. Medicaid will recruit, train and provide consultation for EPSDT providers.
2. Oral Health will provide oral health educational materials for providers, clients, local health departments, family planning clinics, the WIC Program, Managed Care Organizations, and other organizations such as Head Start.
3. Oral Health will arrange for training of EPSDT medical providers who wish to participate in the fluoride varnish program.

C. Specialty Providers - Children with Special Health Care Needs

1. CSHCN will provide technical assistance to Medicaid regarding therapy and audiology services.
2. CSHCN will conduct, through its grantees, targeted provider education regarding programs and services, such as the Newborn Screening Program, Infant Screening Hearing Program, and Genetic Services Network and will make educational materials about these services available to Medicaid.

D. Well Women, Prenatal and Family Planning Providers

1. MCH/FP and Medicaid will collaborate to provide training, consultation and technical assistance to Medicaid, Title V and Title X providers in the delivery of comprehensive well women care, obstetrical care and family planning services.
2. Medicaid and MCH will collaborate to assure that the Prenatal Risk Assessment is jointly reviewed at least yearly and updated as needed to reflect evidence-based practice.
3. FP will sponsor continuing education programs in family planning/women's health for Title X, Title V, WIC, and Medicaid providers.

E. WIC Staff and Providers

1. WIC will educate provider groups about the WIC Program through meetings, conferences, and periodic distribution of WIC provider education packet.
2. Medicaid will provide periodic updates to WIC staff to enhance their ability to refer potentially eligible families to Medicaid.

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3. WIC, MCH, FP, and Medicaid will collaborate on assuring WIC participants receive information on family planning and comprehensive women's health.

VI. PROVIDER CAPACITY

A. All MCH Providers

1. PHPA programs will encourage medical and dental provider participation in the Medicaid Program and its managed care organizations.
2. PHPA programs will refer providers interested in serving the Medicaid population to the appropriate contacts for provider enrollment.

B. Primary Preventive Pediatric Medical and Dental Health Providers

1. Medicaid and MCH will collaborate to recruit and retain medical providers willing to serve children to assure sufficient access to EPSDT services.
2. Oral Health will refer dental providers willing to serve children and pregnant women to the Dental Administrative Services Organization (ASO).
3. Oral Health will assure that the LHD dental clinics they fund serve children on Medicaid.
4. CSHCN and Oral Health will work with Medicaid to increase the number of pediatric dental providers willing to serve children with special health care needs.

C. Specialty Providers

1. CSHCN will collaborate with Medicaid to assure that there are sufficient occupational therapy, physical therapy, speech therapy, and audiology providers, and other specialty care providers that are willing to treat Medicaid recipients and uninsured and underinsured children.
2. CSHCN, in coordination with the Centers of Excellence, will work to identify, recruit and retain providers willing to participate in the Genetic Services Network and conduct targeted provider education and outreach regarding services available.
3. CSHCN and Oral Health will work with Medicaid to increase specialty pediatric dental providers.

D. Obstetrical and Perinatal Providers

1. Medicaid and MCH will collaborate to recruit and retain providers to serve women and infants enrolled in Medicaid and the uninsured.

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2. Medicaid and MCH will encourage perinatal providers to link their prenatal clients with pediatricians prior to delivery to assure access to care for newborns.
3. Medicaid and MCH will work with perinatal providers, hospitals and birthing centers to assure access to appropriate levels of care, especially high-risk pregnancy consultation, for pregnant women and infants.

E. Family Planning Providers

1. Medicaid and FP will collaborate to assure that there are sufficient family planning providers willing to serve women enrolled in Medicaid and any special Medicaid family planning programs.
2. FP will assure that there are providers willing to serve uninsured/underinsured clients on a sliding scale basis.

F. WIC Services

1. WIC will assure that there are sufficient WIC local agencies and clinics statewide.
2. WIC will assure that WIC sites are located in proximity to sites where WIC-eligible clients are receiving other services (e.g., community-based sites, hospitals, prenatal and family planning clinics, etc.).

VII. SYSTEMS COORDINATION

A. All MCH Programs

1. PHPA and Medicaid will collaborate to establish and maintain relationships with providers who serve low-income and Medicaid recipients to help facilitate problem resolution.
2. Medicaid will assure that Managed Care Organizations provide medically necessary services to pregnant women and children.

B. Primary Preventive Care and Oral Health

1. Medicaid and PHPA will collaborate to assure that there are public forums for exchange of information such as the Medicaid Advisory Committee, Maryland Dental Action Coalition and other ad hoc advisory groups.

C. Children with Special Health Care Needs

1. CSHCN will work to increase the awareness among specialty care providers of the role of the MCO Special Needs Coordinators and how to refer families to this resource.

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2. CSHCN in collaboration with Maryland State Department of Education Infants and Toddlers Program will inform providers about the Newborn Hearing Screening Program and assure referrals are made for follow-up services.

D. Pregnant Women and Infants

1. PHPA programs and Medicaid will work to assure that there is a process in place to link women with appropriate services in all Maryland jurisdictions.
2. Medicaid and MCH will partner with perinatal providers to facilitate access to care as well as tracking and management of pregnant women.
3. Medicaid and MCH will encourage all prenatal care providers to complete the Maryland Prenatal Risk Assessment form and refer high-risk women to the appropriate case manager.
4. Medicaid and MCH will work to enhance partnerships between obstetricians and pediatricians to make care more seamless from pregnancy through delivery.

E. Family Planning

1. Medicaid and FP will collaborate to assure that providers are aware of the self-referral option for family planning services.
2. FP, Medicaid and their respective grantees will assist providers with linkages and resources for family planning clients to access primary care services.

F. WIC

1. WIC will partner with MCH, CSHCN, FP and Medicaid to integrate WIC eligibility and application process into provider practice patterns.
2. WIC, MCH, CSHCN, FP and Medicaid will collaborate to identify opportunities to improve service delivery.
3. WIC staff will assure that appropriate referrals are made to health and social services.

VIII. QUALITY ASSURANCE ACTIVITIES

A. All MCH Populations

1. Medicaid will assure that Managed Care Organizations complete the required quality assurance (QA) activities.
2. Medicaid will make QA Reports available on the internet: External Quality Review Organization (EQRO) Audit, analysis of Health Plan Employer Data and Information Set

(HEDIS) measures, Consumer Assessment of Health Plans (CAHPS) survey, encounter data, and value-based purchasing initiatives.

3. PHPA programs will share their quality assurance reports and findings (i.e. audits, customer satisfaction surveys).
4. PHPA will provide QA of LHD programs (dental, child health, family planning, OB, specialty clinics for CSHCN).

B. Primary Preventive Care for Children and Oral Health

1. Medicaid will work with PHPA programs in the development of the EPSDT periodicity schedule and quality standards for the care of children.
2. Medicaid will perform periodic medical record audits to assure that children are getting EPSDT services.

C. Children with Special Health Care Needs

1. CSHCN and Medicaid will collaborate on initiatives to improve the accessibility to specialty services and the quality of those services.
2. CSHCN will perform contract monitoring and administrative oversight for Title V funded case management services performed in local health departments.
3. CSHCN will perform contract monitoring and administrative oversight for the Medical Day Care Centers and collaborate with Medicaid on QA activities for the Centers.
4. CSHCN will participate in the review of Individualized Family Service Plan and Individualized Education Plan school health related services covered by Medicaid.
5. CSHCN will provide consultation to Medicaid as needed regarding preauthorization and medical reviews to determine necessity/appropriateness of specialty services.
6. Medicaid will consult with CSHCN as needed to assure that therapists and other specialty providers meet minimum quality standards and have the appropriate certification and credentials.

D. Pregnant Women and Infants

1. Medicaid will participate in and collaborate with MCH on statewide quality improvement activities such as Maternal Mortality Review (MMR); the Morbidity, Mortality and Quality Review Committee (MMQRC), and the PRAMS Steering Committee.

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2. Medicaid will assure that MCO Directors, MCO Medical Directors, and Medicaid providers are made aware of findings from Maternal Mortality Reviews, Fetal and Infant Mortality Reviews; and the PRAMS program.
3. Medicaid will participate in the Perinatal Clinical Advisory Committee to periodically revise/update the voluntary Maryland Perinatal Systems Standards for birthing hospitals.
4. Medicaid will assure that MCO Directors, Medical Directors, and Medicaid providers are made aware of the Maryland Perinatal Systems Standards.

E. Family Planning

1. FP and Medicaid will collaborate on the development of QA activities relevant to family planning services.
2. Medicaid will participate in annual, regional family planning meetings with Title X providers.
3. Medicaid will participate in Title X Program Reviews as needed/requested by FP.
4. Medicaid and FP will collaborate on systems and service improvement strategies for family planning.

F. WIC

1. WIC will include Medicaid as a participant in WIC strategic planning initiatives.
2. WIC, through its Advisory Council, will assure that the unique needs of Medicaid recipients are considered in customer service and quality improvement initiatives.

EFFECTIVE DATE

This COOPERATIVE AGREEMENT is effective upon the signatures of the authorized officials of the Prevention and Public Health Administration and the Maryland Medical Assistance Program. It shall remain in effect for a period of five years from the date the COOPERATIVE AGREEMENT is signed, or until either party provides written notification of termination. Termination notice shall be given to the other party at least 30 days in advance of the termination date.

MODIFICATIONS

The parties or their designees may enter into supplements and modifications to this agreement jointly.

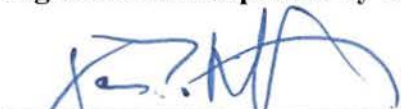
TN No: 15-0017

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Effective Date: October 1, 2015

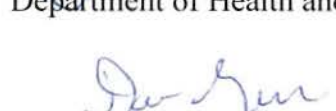
Agreement Acceptance by Signature:



Van T. Mitchell, Secretary
Department of Health and Mental Hygiene

7/12/15

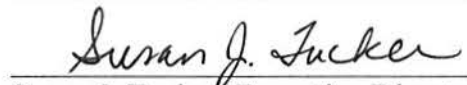
Date



Michelle Spencer, Director
Prevention and Health Promotion Administration

7/1/15

Date

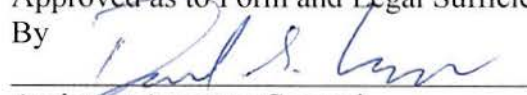


Susan J. Tucker, Executive Director
Office of Health Services
Medical Assistance Program

7/2/15

Date

Approved as to Form and Legal Sufficiency, this 14 day of July 2015,
By



Assistant Attorney General

TN No: 15-0017

Supersedes: 10-10

Approval Date: February 16, 2016

Effective Date: October 1, 2015

**INTRA-AGENCY AGREEMENT
BETWEEN
MARYLAND MEDICAL ASSISTANCE PROGRAM
AND
OFFICE OF HEALTHCARE QUALITY**

This Intra-agency Agreement (“Agreement”) is made effective this __19th__ day of __February__, 2025, by and between the Maryland Medical Assistance Program within the Office of Health Care Financing (“Medicaid”), and the Office of Healthcare Quality (“OHCQ”), both of which are offices within the executive agency, the Maryland Department of Health (the “Department,” or “MDH”).

WHEREAS, Section 1902(a)(9) of the Social Security Act (42 U.S.C. § 1396a(a)(9)) requires that Maryland’s State Plan for medical assistance must designate the State health agency, or other appropriate State medical agency, that shall be responsible for establishing and maintaining health standards for private or public institutions in which Medicaid recipients under the plan may receive services; and

WHEREAS, the OHCQ is the agency within the Department charged with monitoring the quality of care in Maryland’s health care facilities and community-based programs through surveying, licensing, certification, and enforcement activities;

WHEREAS, in accordance 42 U.S.C. § 1396a(a)(9), Section 4.11 of the Maryland Medicaid State Plan designates the OHCQ as the State agency responsible for establishing and maintaining health standards for private or public institutions that provide services to Medicaid recipients; and

WHEREAS, 42 C.F.R. § 431.610(f) requires that the State Plan must provide for a formal written intra-agency arrangement between the Medicaid agency and the survey agency designated for establishing and maintaining health standards for institutions providing services to Medicaid recipients that covers the activities of the survey agency in carrying out its responsibilities; and

WHEREAS, the Maryland Department of Health wishes to formalize the arrangement it intends to utilize to ensure that health and safety standards are met for all institutions providing services to Medicaid recipients, whereby the Medicaid will rely on the OHCQ’s pre-existing inspection and licensure activities to satisfy the health and safety requirement outlines in 42 U.S.C. § 1396a(a)(9) and 42 C.F.R. § 431.610.

NOW, THEREFORE, the parties hereto agree as follows:

I. TERMS

- A. OHCQ will perform its pre-existing and established oversight, inspection, and licensure duties for health care institutions in Maryland as required under the Health-General Article and pursuant to the delegation of authority by the Secretary of Health and Human Services by the Agreement made under Section 1864 of the Social Security Act (42 U.S.C. § 1395aa) (the “1864 Agreement”). These include conducting various types of surveys to determine compliance with federal and state regulations, conducting certification and recertification activities on behalf of the Centers for Medicare and

Medicaid Services (“CMS”), issuing State licenses that authorize a facility or program to do business in Maryland, and pursuing enforcement and/or disciplinary action against facilities that have fallen out of compliance with state or federal regulations.

- B. OHCQ agrees that, in carrying out the duties described in paragraph I.A, above, its inspectors surveying the premises of a provider will complete inspection reports, note on completed reports whether or not each requirement for which an inspection is made is satisfied, and document deficiencies in reports. OHCQ further agrees that it will keep on file all information and reports used in determining whether participating facilities meet Federal requirements, and will make all such information and reports required under this Agreement readily accessible to HHS and the Medicaid agency as necessary for meeting other requirements under the State plan; and for purposes consistent with the Medicaid agency's effective administration of the program.
- C. Medicaid will rely on OHCQ’s oversight, inspection, and licensure activities for the purpose of ensuring that established health and safety standards are met for institutions providing services to Medicaid recipients in accordance with 42 U.S.C. § 1396a(a)(9) and 42 C.F.R. § 431.610. Specifically, Medicaid will rely on an institution’s licensure and certification status with OCHQ as the determinative factors for whether requisite health and safety standards are met.
- D. Both Medicaid and OHCQ agree that the federal requirements and the forms, methods and procedures that the CMS Administrator designates will be used to determine provider eligibility and certification under Medicaid.
- E. OHCQ acknowledges that Medicaid will rely on OHCQ’s determinations and assessments for this purpose.

II. EFFECTIVE DATE, TERMINATION, AND AMENDMENTS

- A. This Agreement shall be effective upon its full execution by the parties, and supersede any and all previous agreements between Maryland Medicaid and OHCQ.
- B. This Agreement shall remain in full force and effect until terminated by either Medicaid or the OHCQ in writing; provided, however, that this Agreement will terminate immediately if changes in relevant federal and state law and/or regulations and/or provisions of the Maryland Medicaid State Plan render performance hereunder illegal or impossible.
- C. This Agreement may only be amended by written agreement of both DHS and MDH.

III. ADMINISTRATORS

All questions or concerns regarding any matter arising under or relating to this Agreement should be directed to the parties’ respective administrators:

For Medicaid: Charles Crisp
Director of Medicaid Provider Services
(410) 767-1488
charles.crisp@maryland.gov

For OHCQ: Tia Witherspoon-Udocox
Executive Director
(410) 402-8556
lauren.murray@maryland.gov

IV. MISCELLANEOUS

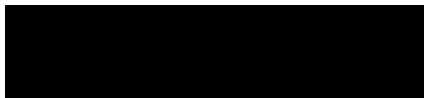
- A. Nothing in this Agreement may be construed as abrogating the responsibilities imposed by any other agreements entered into by Medicaid, OHCQ, or MDH.
- B. This Agreement shall be governed and construed in accordance with the laws of the State of Maryland.

V. SIGNATURES

On behalf of the parties, the signatories below agree to the terms and conditions of this Agreement. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement.

FOR MEDICAID:



Ryan B. Moran, DrPH, MHSA
Deputy Secretary, Health Care Financing and Medicaid Director
Maryland Department of Health

2/18/2024

Date

FOR OHCQ:



Tia Witherspoon-Udocox
Executive Director
OHCQ

02.19.2025

Date

(a) **Medical Review Process For Determining That A Person Cannot Reasonably Be Expected To Be Discharged From The Medical Institution and Return Home**

The Medical Review Process is performed for the Maryland Department of Health Mental and Mental Hygiene (DHMH) by the contractual Utilization Control Agent (UCA) that conducts utilization reviews in nursing facilities and other long term care facilities.

1. The applicant's attending physician completes Part II of the DHMH Form 4245 (LTC), Physician Report (see facsimile on page 3 of this Attachment). The physician returns the form to the applicant who in turn forwards it to the local department of social services (LDSS) or the Bureau for Long Term Care Eligibility (BLTCE). The LDSS or BLTCE forwards a copy of the Physician Report to the UCA.
2. Using the medical information provided with the request for medical eligibility (on file with the UCA), the Physician Report, and other information obtained from the facility, the UCA completes a medical review to determine if there is a reasonable expectation that the applicant/recipient will resume living in the community. The UCA notifies the applicant/recipient of the decision and his/her right to a hearing via Form 4246 (LTC), Notice of Medical Review Decision. (See facsimile on page 4-5 of this attachment).
3. If the applicant/recipient appeals the UCA decision, the Office of Health Services (OHS) reviews the case, either affirms or reverses the UCA decision. If OHS reverses the UCA decision, OHS notifies the recipient, the UCA, the LDSS/BLTCE, and the Division of Recoveries of the result of the review. If OHS affirms the UCA decision, OHS requests that the Office of Administrative Hearings schedule a hearing on the matter. When the appeal decision is rendered after the hearing, the OAH notifies the recipient, the LDSS/BLTCE, OHS, the Division of Recoveries, and the UCA of its decision.
4. An explanation of a lien is provided to an applicant by way of form DHMH 4244 (LTC). See page 6-7 of this Attachment for a facsimile of this form.

(b) **Definitions:**

1. **Individual's home** means any shelter which the institutionalized person used as his principal place of residence immediately preceding admission to the long term care facility. The home includes the parcel of land on which the shelter is situated and any related outbuildings necessary to its operation. One residence may be considered home property.
2. **Equity interest in the home** means co-ownership of the home which is not the result of a transfer of the property for less than fair market value within 2 years before institutionalization.

3. **Residing in the home for at least 1 (or 2) years(s) on a continuous basis means** using the home as the principal place of residence for 1 (or 2) year(s).
 4. **Discharge from the medical institution and return home** means the release of a person from the institution for the purpose of returning to the home for permanent residence.
 5. **Lawfully residing** means residing in the home with the permission of the owner or, if under guardianship, the owner's legal guardian.
- (c) A son or daughter can establish that he or she provided care by submitting to the Program convincing evidence establishing the provision of care for his or her parent.

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTICE OF MEDICAL REVIEW DECISION – HOME PROPERTY

Date _____

Re _____
Name

Case Number

Dear _____:

This is to notify you that a medical review was held on _____ to decide if there is a reasonable expectation that the above named person will be able to resume living in his/her home property. The review was based on medical information provided by his/her attending physician and the Long Term Care Facility. The decision is checked below:

- ☐ The above named person can reasonably be expected to be discharged from the Long Term Care Facility to resume living in his/her home property.
- ☐ The above named person cannot reasonably be expected to be discharged from the Long Term Care Facility to resume living in his/her home property. The Division of Medical Assistance Recoveries will contact you concerning the placing of a lien on this person's real property.

The person's medical condition will be reviewed every six months or when a change is indicated, and you will be notified if the above decision is changed. The Medical Assistance Program's authority to make this decision is based on COMAR 10.09.24.15A-2(2). If you do not agree with the medical review decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter.

Sincerely,

Utilization Control Agent_____
Telephone Number

cc: Recipient
Division of Medical Assistance Recoveries

Local Department of Social Services

DHMH 4246(LTC) Revised 04/13

TN # 13-06Supersedes TN # 86-17

Approval Date

JUL 02 2013

Effective Date

APR 01 2013

Summary of Procedures for Hearing

If you are dissatisfied with the Medical Review decision you have the right to appeal that decision to the Maryland Office of Administrative Hearings. Send your written request for a hearing to:

Executive Director
Office of Health Services
201 West Preston Street
Baltimore, Maryland 21201-2399
Attention: Appeals

The appeal must be filed within 90 days from the date of this letter. Please include a copy of this notice with your appeal. Prior to the hearing, an Administrative Review of the decision of the Utilization Control Agent will be conducted. You will be notified of the result of the Administrative Review and if the decision of the Utilization Control Agent is affirmed, a hearing will be scheduled. The hearing will be conducted by the Office of Administrative Hearings. You may be represented by yourself, your designated representative, legal counsel, or any other person chosen. Any witnesses or additional medical information or documents may be presented to help establish pertinent facts and circumstances. You have the right to examine the information on which the decision was based. The Administrative Law Judge will decide whether or not the decision of the Utilization Control Agent was correct. This decision will be sent to you as soon as possible.

You may obtain free legal aid through the Legal Aid Bureau in many areas of the State. Consult your telephone directory for the address and telephone number of the Legal Aid office nearest you, or contact your worker at the Local Department of Social Services for this information.

DHMH 4246

TN # 13-06Supersedes TN # 86-17

Approval Date

~~JUL 02 2013~~

Effective Date

~~APR 01 2013~~

MARYLAND MEDICAL ASSISTANCE PROGRAM
EXPLANATION OF A LIEN

Date _____

RE: _____
Name Case Number

Dear _____,

This is to notify you that, based on the application filed on _____, the above named person owns real property against which the Medical Assistance Program may place a lien. This is based on COMAR 10.09.24.15A-2(2). The real property on which a lien may be placed is:

ADDRESS OR DESCRIPTION

ADDRESS OR DESCRIPTION

A lien is a claim on the property of a person as security for the payment of a just debt. Its purpose in the Medical Assistance Program is to recover Program expenditures paid on behalf of the person's medical care while he/she is residing in a Long Term Care Facility. A lien is placed on the person's real property:

- When the person must pay all but a minimal amount of his/her income for his/her medical care, including Long Term Care; and
- When the Program has determined based on a Medical Review, there is no reasonable expectation that the person will be discharged from the Long Term Care Facility and resume living in the community.

When a lien is imposed on the person's real property including the home property, the person retains ownership and control of the property to the extent of his/her ownership interest in the property. The lien is imposed on his/her ownership interest and will dissolve if and when the person is discharged from the Long Term Care Facility and resumes living in the community.

Please read the reverse side of this notice for additional information concerning liens.

Specific questions concerning the Impact of a lien on the person's real property may be directed to the Division of Medical Assistance Recoveries, P.O. Box 13045, Baltimore, Maryland 21203 or call _____.

Sincerely,

Eligibility Technician

Department of Social Services

Telephone Number

DHMH 4244 (LTC)

TN # 13-06
Supersedes TN # 86-17

Approval Date **JUL 02 2013**

Effective Date **APR 01 2013**

Additional Information Concerning Liens

The Medical Review is completed by the Medical Assistance Program's Utilization Control Agent. The decision of the Utilization Control Agent is based on medical information provided by the person's attending physician and the Long Term Care Facility. You will receive notice of the decision and you will be given the opportunity for a hearing if you do not agree with the decision.

Selling, giving away or otherwise disposing of the home or any other real property for less than fair market value may cause a person to be ineligible for Medical Assistance.

No lien may be imposed on the person's home property when it is occupied by the person's spouse, or child under age 21, or blind or disabled child of any age, or a brother or sister who has an equity interest in the home property and who has resided in the property for a period of at least one year immediately before the date of the person's admission to a Long Term Care Facility.

Should the Medical Review Process or imposition of a lien against the person's real property be delayed because of the person's mental incompetence, conditional Medicaid Assistance eligibility may be granted by the Local Department pending the appointment of a legal representative for the person. The effective date of the lien will be the date conditional eligibility was granted.

TN # 13-06

Supersedes TN # 86-17

Approval Date

~~JUL 02 2013~~

Effective Date

~~APR 01 2013~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Maryland

- A. The following charges are imposed on the categorically needy for the services other than those provided under section 1905 (a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deduct	Co-Ins	Copay	
Prescription Services			\$1	Co-payment for prescriptions for generic drugs and brand name drugs on the preferred drug list except for those specifically excluded in §4.18(b).
			\$3	Co-payment for prescriptions for brand name drugs not on the preferred drug list.

JUL 29 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

B. The method used to collect cost sharing charges for categorically needy individuals:

- ☒ Providers are responsible for collecting the cost sharing charges from individuals.
- ☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers are not allowed to deny services for recipients who are unable to pay the copay.

TN No. 05-02

Supersedes

Approval Date: NOV 15, 2004

Effective Date: NOV 1, 2004

TN No. 91-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

1. Children Under 21 – Notation of age is included on MA card, in the EVS system and recipient information in the payment system.
2. Pregnant Women – Notation of pregnancy made by the prescriber or dispenser on the invoice or magnetic tape bill.
3. Institutionalized Individuals – Noted in the EVS system.
4. Emergency services that meet requirements in 42 CFR 447.53 (b).
5. Family Planning – Noted by NDC code identification for all exempted products.
6. Recipients in Hospice – Noted in EVS system.
7. Any complaints received by the state will be investigated and monitored.

E. Cumulative maximums on charges:

- ☒ State policy does not provide for cumulative maximums.
- ☐ Cumulative maximums have been established as described below:

TN No. 05-02

Supersedes

Approval Date: NOV 15, 2004

Effective Date: NOV 1, 2004

TN No. 91-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Maryland

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct	Co-Ins.	CoPay	
Prescription Services			\$1	Co-payment for prescriptions for generic drugs and brand name drugs on the preferred drug list except for those specifically excluded in §4.18(b).
			\$3	Co-payment for prescriptions for brand name drugs not on the preferred drug list.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

B. The method used to collect cost sharing charges for medically needy individuals:

- ☒ Providers are responsible for collecting the cost sharing charges from individuals.
- ☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers are not allowed to deny services for recipients who are unable to pay the copay.

TN No. 05-02

Supersedes

Approval Date NOV 15, 2004

Effective Date: November 1, 2004

TN No. 91-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

1. Children Under 21 – Notation of age is included on MA card, in the EVS system and recipient information in the payment system.
2. Pregnant Women – Notation of pregnancy made by the prescriber or dispenser on the invoice or magnetic tape bill.
3. Institutionalized Individuals – Noted in the EVS system.
4. Emergency services that meet requirements in 42 CFR 447.53 (b).
5. Family Planning – Noted by NDC code identification for all exempted products.
6. Recipients in Hospice – Noted in EVS system.
7. Any complaints received by the state will be investigated and monitored.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

TN No. 05-02

Supersedes _____ Approval Date NOV 15, 2004 Effective Date: November 1, 2004

TN No. 91-19

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 4.18-D
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Premiums Imposed on Low Income Pregnant Women and Infants

- A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

TN No. 92-11 NOV 01 1991
Supersedes _____ Approval Date JUN 05 1992 Effective Date _____
TN No. _____

HCFA ID: 7986E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 4.18-D
Page 2
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Maryland

C. State or local funds under other programs are used to pay for premiums:

☒ Yes

☐ No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

TN No. 92-11
Supersedes
TN No. _____

Approval Date JUN 05 1992

Effective Date NOV 01 1991

HCFA ID: 7986E

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

ATTACHMENT 4.18-E
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

TN No. 92-11
Supersedes _____ Approval Date JUN 05 1992 Effective Date NOV 01 1991
TN No. _____

HCFA ID: 7986E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 4.18-E
Page 2
OMB No.:0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Maryland

C. State or local funds under other programs are used to pay for premiums:

☒

Yes

☐

No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

TN No. 92-11

Supersedes

TN No. _____

Approval Date JUN 05 1992

Effective Date

NOV 01 1991

HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

A. For groups of individuals with family income above 100 percent but below 150 percent of the FPL:

1. Cost sharing

- a. X / No cost sharing is imposed.
- b. / Cost sharing is imposed under section 1916A of the Act as follows
(specify the amounts by group and services (see below)):

Group of Individuals	Item/Service	Type of Charge		*Method of Determining Family Income (including monthly or quarterly period)
		Deductible	Co-insurance Co-payment	

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

Attach a schedule of the cost sharing amounts for specific items and services and the various eligibility groups.

b. Limitations:

The total aggregate amount of cost sharing and premiums imposed under section 1916A for an individuals in the family may not exceed 5 percent of the family income of the

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

family involved, as applied on a monthly and quarterly basis as specified by the State above.

- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.

c. No cost sharing will be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care, (as defined in section 1905(o) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State Plan, to spend for costs of medical care all but the minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. ☐ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
2. ☐ (If above box selected) Providers permitted to reduce or waive cost sharing on a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.

B. For groups of individuals with family income above 150 percent of the FPL:

1. Cost sharing amounts

a. X / No cost sharing is imposed.

b. / Cost sharing is imposed under section 1916A of the Act as follows (specify amounts by groups and services (see below)):

Group of Individuals	Item/Service	<u>Type of Charge</u>		*Method of Determining Family Income (including monthly or quarterly period)
		Deductible	Co-insurance Co-payment	

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

Attach a copy of the schedule of the cost sharing amounts for specific items and the various

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

eligibility groups.

b. Limitations:

- The total aggregate amount of all cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.

c. No cost sharing shall be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care, and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(0) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

d. Enforcement

- I. ☐ / Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
2. ☐ / (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.
3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.
4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

- a. ☒ / No premiums are imposed.
- b. ☐ / Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

b. Limitation:

- The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.

c. No premiums shall be imposed for the following individuals:

- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Pregnant women;
- Any terminally ill individual receiving hospice care, as defined in section 1905(o);
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of
- medical care all but a minimal amount of the individual's income required for personal needs; and
- Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. ___/ Prepayment required for the following groups of individuals who are applying for Medicaid: The State determines the child meets eligibility criteria and notifies the family that the child will be eligible if the family pays the premium. The family sends the initial premium within 30 days. For children who do not have MCO history within 120 days, the State sends the family an MCO enrollment packet. The family has 21 days to choose an MCO or the child will be assigned to an MCO in their area
2. ___/ Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

3. ___/ Payment will be waived on a case-by-case basis for undue hardship.

C. Period of determining aggregate 5 percent cap

Specify the period for which the 5 percent maximum would be applied.

___/ Quarterly

___/ Monthly

D. Method for tracking cost sharing amounts

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

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

State of Maryland

Introduction

Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

Payments for care or service will not exceed the amounts indicated in the following section below and participation in the program will be limited to providers of service who accept as payment in full the amounts so paid.

The Single State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on cost of providing care or service, or fee plus cost of materials.

Reimbursement Limitations:

- A. The Department may not reimburse the claims received by the Program for payment more than 12 months after the date of services.
- B. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:
 - (1) Approved, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and
 - (2) Denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.
- C. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 12 months of the earliest date of service.
- D. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 12 months period, or within 60 days of rejection, whichever is later.
- E. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 12 months of the date on which eligibility was determined.

Payment for Services: Methods and Standards for Establishing Payment Rates

- I. Maryland Inpatient Hospital/Uncompensated Care Methodology
- II. Disproportionate Share Hospitals
- III. D.C. Hospitals
- IV. Out of State Hospitals

- I. Inpatient Hospital Services

In 1977, the Department of Health, Education and Welfare (now the Department of Health and Human Services) granted the State of Maryland a waiver from Medicare reimbursement principles. Under this All Payer Hospital Rate System, all Maryland payers, including Medicare and the Program, reimburse inpatient hospital services at prospective rates reviewed and approved by the Maryland Health Services Cost Review Commission (HSCRC).

- A. All hospitals located in Maryland which participate in the Program and are regulated by the All Payer Hospital Rate System, except those listed below, will charge, and payers will reimburse, according to rates approved by the HSCRC, pursuant to the HSCRC statute and regulation. Under this system, all regulated hospitals are required to submit to the HSCRC data using a uniform accounting and reporting system.

Hospitals may request that the HSCRC conduct a full rate review. During a full rate review, the HSCRC compares the hospital's charge per case with those in the hospital's peer group resulting in the HSCRC developing new rates for the hospital under review.

The HSCRC posts each hospital's rates by rate center on the HSCRC's website:
<http://www.hscrc.state.md.us/index.cfm>

Uncompensated Care Methodology: The HSCRC's provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland. Uncompensated care includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for

care. The uncompensated care provision in rates is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year.

The HSCRC uses a blend of a regression methodology and actual past uncompensated care to determine the uncompensated care amount in rates. The regression methodology is a vehicle to predict actual uncompensated care costs in a given year. The uncompensated care regression estimates the relationship between a set of explanatory variables and the rate of uncompensated care observed at each hospital as a percentage of gross patient revenue. Explanatory variables include variables such as, the proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room, the proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases, the proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room, and the proportion of a hospital's total charges from outpatient charges.

- B. The Program will make no direct reimbursement to any Maryland State-operated chronic hospital, or psychiatric hospital.
- C. An acute general or special hospital other than private psychiatric hospitals whose rates are not set by the HSCRC will be reimbursed according to the lesser of:
 - 1. Medicare standards for retrospective cost reimbursement described in 42 CFR Part 413; or
 - 2. On the basis of charges if less than reasonable cost.

For all inclusive rate providers that include provider based physician services, an average cost per for provider based physician services will be developed and paid in accordance with retrospective cost reimbursement principles. In calculating retrospective cost reimbursement rates, the Department or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, or groups of costs, or costs of specific groups of patients. When the cost, or group, or groups of costs, designated, cover services rendered to all patients, including Medical Assistance recipients, operating costs applicable to all patients will be reduced by the amount of the restricted grants, gifts, or income from endowments thus resulting in a reduction of allowable costs.

Payment for administrative days will be according to: (1) A projected average Medicaid nursing home payment rate, or (2) if the hospital has a unit which is a skilled nursing facility, a rate which is the lesser of that described in (1) or the allowable costs in effect under Medicare for extended care services to patients of such unit.

- D. The Program will reimburse private psychiatric hospitals in Maryland by a prospective payment system per diem rate, based on rates set by the HSCRC pursuant to the HSCRC methodology.

The HSCRC establishes approved rates for units of service in the various revenue producing departments (rate centers). The rates include adjustments for such items as inflation, volume changes, pass-through costs, and uncompensated care. A description of the HSCRC's uncompensated care methodology is provided in Section I, Letter A (above).

The Program's private psychiatric hospital prospective payment system (PPS) aggregates the HSCRC's rate center-based rates to one per diem rate using a weighted average. The per diem is further reduced to account for bad debt, discounts, capital costs, public relations, lobbying and certain educational expenses as reported on the private psychiatric hospital's cost reports and revenue statements.

Review of cost reports and revenue statements produced a 6% reduction on average and establishes the recommended PPS rate at 94% of the HSCRC rate. Payment for administrative days in private psychiatric hospitals will be made according to: (1) A projected average Medicaid nursing home payment rate, or (2) the administrative day rate for recipients waiting placement in a residential treatment center.

- E. Private freestanding pediatric rehabilitation hospitals in Maryland not approved for reimbursement according to the HSCRC rates shall be reimbursed for inpatient expenditures using a prospective payment system consisting of per diem rates based on categories of service on the providers fiscal year cost report for 2004 after audit and adjustments. The base per diem rates shall be adjusted annually by a market basket update factor in the Centers for Medicare and Medicaid Annual Update factors for Long Term Care Hospital Prospective Payment System.
- F. Reimbursement of Medically Monitored Intensive Inpatient Treatment Services Provided in an Intermediate Care Facility for patients under the age of 21:

The Department shall pay the intermediate care facility the lower of the provider's usual and customary charge or the provider's per diem costs for covered services according to the principles established under Title XVIII of the Social Security Act, up to a maximum of \$400 per day. The \$400 per day maximum payment will be updated annually by the Centers for Medicare and Medicaid Service's published federal fiscal year market basket increase percentage relating to hospitals excluded from the prospective payment system. The average increase in the Department's reimbursement to the provider per inpatient day for each fiscal year over the cost-settled rate for the previous fiscal year may not exceed the rate of increase of the Hospital Wage and Price Index plus 1 percentage point, described in 42 CFR §413.40, as amended. The target rate percentage increase for each calendar year shall equal the prospectively estimated increase in the Hospital Wage and Price Index (market basket index) for each calendar year, plus 1 percentage point. Since the cost reporting period spans portions of 2 calendar years, the Program shall calculate an appropriate prorated percentage rate based on the published calendar year percentage rates.

- G. A residential treatment center admits patients between the ages of 12 and 21. The Department reimburses a residential treatment center, except an in-state children's residential treatment center, the least of: (1) the provider's usual and customary charge unless the service is free to individuals not covered by Medicaid; (2) the provider's per diem cost for covered services established in accordance with Medicare principles of reasonable cost reimbursement as described in 42 CFR 413; (3) \$750 per day effective July 1, 2021. The \$750 per day will be updated annually by the Centers for Medicare and Medicaid Services' published federal fiscal year market basket increase percentage relating to hospitals excluded from the prospective payment system.

Effective January 1, 2023, the \$750 per day rate is rebased to \$850 per day and will be updated annually as identified above plus a 1% update factor. The Department rebases prices between every two and four 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. In years which rates are not rebased, rates are subject to annual indexing.

1. Qualified non-facility individual practitioners may be directly reimbursed for somatic, dental, or other medically necessary services not included in the per diem rate which are provided to children in a residential treatment center.
2. Such reimbursement is subject to the payment methodologies that are otherwise specified in the State Plan.

- H. Children's residential treatment center: A children's residential treatment center is a residential treatment center that admits patients 12 years of age and under. An in-state children's residential treatment center shall be reimbursed the least of:

(1) the provider's usual and customary charge unless the service is free to individuals not covered by Medicaid;

(2) the provider's per diem cost for covered services established in accordance with Medicare principles of reasonable cost as described in 42 CFR 413; or (3) \$750 per day effective July 1, 2021. The \$750 per day will be updated annually by the Centers for Medicare and Medicaid Services' published federal fiscal year market basket increase percentage relating to hospitals excluded from the prospective payment system.

Effective January 1, 2023, the \$750 per day rate is rebased to \$850 per day and will be updated annually as identified above plus a 1% update factor. The Department rebases prices between every two and four 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. In years in which rates are not rebased, rates are subject to annual indexing.

1. Qualified non-facility individual practitioners may be directly reimbursed for somatic, dental, or other medically necessary services not included in the per diem rate which are provided to children in a residential treatment center.
2. Such reimbursement is subject to the payment methodologies that are otherwise specified in the State Plan.

II. Disproportionate Share Payments

A disproportionate share payment (DSP) for hospitals serving a disproportionate share (DSH) of low income patients shall be implemented in the following manner:

- A. A Maryland hospital shall be deemed a disproportionate share hospital for purposes of a disproportionate share payment if:
1. The hospital's Medicaid (Title XIX) inpatient utilization rate as defined in section 1923 (b) (2) is at least one standard deviation above the mean Medicaid (Title XIX) inpatient utilization rate for Maryland hospitals that are Medicaid providers; or
 2. The hospital's low-income utilization rate, as defined in section 1923(b)(3), exceeds twenty-five percent (25%); and
 3. The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetrical services to individuals who are entitled to Medical Assistance for such services under Maryland Medicaid's State Plan, except that the requirements of A(3) shall not apply to a hospital if:
 - a. Inpatients are predominantly individuals under 18 years of age; or
 - b. It did not provide non-emergency obstetric services as of December 22, 1987; and
 4. The hospital's Medicaid inpatient utilization rate is not less than 1 percent.
- B. Disproportionate Share Payments for Disproportionate Share Hospitals
1. For acute care general, free-standing chronic care, and free-standing pediatric-rehabilitation hospitals, the DSP shall equal the minimum DSP rate required by federal law.
- For these "types" of hospitals not governed by the Maryland Medicare Waiver, additional adjustment payments in the amount described below in items 2a through 2f shall be made.
- For these "types" of hospitals governed by the Maryland Medicare Waiver, rates set in accordance with the Maryland Waiver already include the DSP, and no additional payment will be made.

The following definitions are used for 2a through 2f below:

LI	Low income costs in most recent full fiscal year determined in advance of each fiscal year for FY 1994 and subsequent years. (For FY 1993, FY 1991 data will be used).
MA	Medical Assistance payments in most recent full fiscal year, determined in advance of each fiscal year for FY 1994 and subsequent years. (For FY 1993, FY 1991 will be used).
MAP	Medical Assistance payments in the fiscal year for which the DSP is being made.
"Low Income"	Consistent with 42 U.S.C. 1396r-4 hospital costs equal the sum of (1) a hospital's inpatient Medicaid costs; (2) its state and local government inpatient cash subsidies; and (3) its charity care inpatient costs. Medicaid "costs" shall be deemed equal Medicaid payments by the Medicaid program.
"Charity care inpatient costs"	Hospital costs that are not reimbursed through any patient or third party reduced by the amount of gifts, restricted grants or income from endowments. Third party payments include Medicaid payments for the cost of care, but do not include disproportionate share payments.
"State and local government inpatient cash subsidies"	The payments for hospital costs from State or local government health agencies that are not intended as reimbursement for costs directly associated with particular patients, but are provided more generally for operating costs of the institution. Such subsidies do not include Medicaid payments or disproportionate share payments.

- 2-a. For free-standing psychiatric hospitals with charity care inpatient costs exceeding 40 percent of total inpatient hospital costs, the disproportionate share payment shall equal the greater of: the hospital's annual "low income" costs (LI) divided by its annual inpatient Medicaid cost (MA), minus one, all multiplied by two, and then multiplied by its inpatient Medicaid payment $((LI/MA)-1)2(MAP)$ or the minimum DSP required by federal law.
- 2-b. For free-standing psychiatric hospitals with charity care inpatient costs less than or equal to 40 percent of total inpatient hospital costs, the disproportionate share payment shall equal the minimum DSP required by federal law.
- 2-c. For free-standing rehabilitation hospitals with charity care inpatient costs exceeding 20 percent of total inpatient hospital costs, the disproportionate share payment shall equal the greater of: the hospital's annual "low income" costs (LI) divided by its annual inpatient Medicaid Costs (MA), minus one, all multiplied by its inpatient Medicaid payment (MAP): $((LI/MA)-1)(MAP)$; or the minimum required by federal law.

- 2-d. For free-standing rehabilitation hospitals with charity care inpatient costs less than or equal to 20 percent of total inpatient hospital costs, the disproportionate share payment shall equal the minimum required by federal law.
 - 2-e. One or more payments shall be made for each year which, in the aggregate, shall cover the entire fiscal year. DSH status and DSP depends on DSHs providing necessary qualifying information to the Department on a timely basis. DSP for any federal fiscal year are subject to the DSH allotment set for Maryland.
 - 2-f. DSP for a hospital will not exceed limits established in accordance with section 1923(g) of the Social Security Act.
- C. Any redistribution of an overpayment for DSH shall first be redistributed within the same category of facility as the overpayment, i.e. Public Psychiatric Hospitals, Public Rehab Hospitals or Private General Hospitals. The redistribution shall be to all hospitals in the group who have not received the maximum for which they are eligible. The distribution shall be based on the percentage of each hospital's unused capacity to the total unused capacity for the category. If all available overpayments are not allocated in this manner the remaining categories shall be combined into one group and the remaining overpayment amount shall be based on the percentage of each hospital's available capacity to the total available capacity for all remaining hospitals.

III. District of Columbia (D.C.) Hospitals

A. Inpatient:

A hospital located in D.C. shall be paid a percentage of charges based on the result of **multiplying** the following Factors 1-4 then **adding** Factor 5:

- Factor 1 is the report period cost-to-charge ratio. This factor, which is determined by an analysis of the hospital's most recent cost report performed by the Maryland Medical Assistance Program or its designee, establishes the cost-to-charge ratio for the hospital during the cost report period.
- Factor 2 is the cost-to-charge projection ratio. This factor, which is determined by an analysis of the hospital's three most recent cost reports performed by the Program or its designee, projects the cost-to-charge ratio from the cost report periods two years prior to the latest cost report to the prospective payment period. The annual rate of change is applied from the mid-point of the report period used to develop Factor 1 to the mid-point of the prospective payment period. To reflect the accelerating pace of cost-to-charge ratio decreases, Factor 2 shall not be greater than 1.000.
- Factor 3 is the efficiency and economy adjustment. This factor represents the fraction of the hospital's costs which the MMAP finds to be efficiently and economically incurred. In making this finding, the MMAP compares the hospital's cost of providing care to program recipients classified into APR-DRGs/age categories with the costs of providing care to identically classified program recipients in Maryland hospitals. In order to recognize the possibility that the severity of illness within APR-DRG/age categories may be greater for program recipients treated in D.C. hospitals than in Maryland hospitals, the MMAP will adjust cost differences for positive APR-DRG/age adjusted length-of-stay (LOS) differences between the hospital and the Maryland LOS. For hospitals other than Rehabilitation Hospital, the MMAP shall give 80% credit for positive LOS differences for DRGs other than 462 (Rehabilitation) the cost of longer stay days is approximately 30% of the cost of average days. For hospitals with stays in DGR 462 the MMAP shall give 100% credit for the positive LOS difference because in DRG 462 the cost of longer stay days equals the cost of an average day.

Costs of D.C. hospitals used in the above comparison are adjusted to reflect labor market differences between D.C. hospitals and Maryland hospitals as a ratio, based upon adjusted information as supplied in Hospital Statistics issued by the American Hospital Association as applied to the percentage of D.C. hospital costs which are labor expenses. If cumulative information starting from 1989 as supplied in Hospital Statistics reveals that the:

- (1) Cumulative D.C. labor costs increase per full time equivalent (FTE) is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is greater than the cumulative increase in Average Hourly Earnings (AHE) for Hospital Workers as reported by the Bureau of Labor Statistics, then the Program will use information as supplied in the 1990-1991 edition of Hospital Statistics; or if,
 - (2) Cumulative D.C. labor costs increase per FTE is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is less than the cumulative increase in AHE, then the 1989 data supplied in the 1990-1991 edition of Hospital Statistics will be adjusted to recognize the portion of the D.C. increase in labor cost per FTE which does not exceed the cumulative AHE; or if
 - (3) Cumulative D.C. labor costs increase per FTE is less than the cumulative Maryland labor cost increase per FTE in any edition of Hospital Statistics, then the labor market difference shall be measured using that current issue of Hospital Statistics.
- Factor 4 is the uncompensated care ratio consisting of charity care and bad divided by net revenue from the Medicare cost report.
 - (1) In no case shall the MMAP pay more than charges, thus the percent of charges paid shall not be greater than 1.000.
 - (2) Payment for administrative days will be according to: (a) a projected average Medicaid nursing home payment rate; or (b) if the hospital has a unit which is the lesser of that described in (a), or the allowable costs in effect under Medicare for extended services provided to patients of the unit.
 - (3) For acute children's hospitals, the MMAP will pay based on maintaining the revenue at fiscal 2009 level. For all other DC hospitals the revenue shall be maintained at the 2010 level.
 - Factor 5: Beginning July 1, 2011 rates calculated according to the four factors above should be adjusted upward by 2.0 percentage points.

IV. Out of State Hospitals

- A. A hospital located outside of Maryland, but not in D.C. shall be reimbursed the lesser of its charges or the amount reimbursable by the host state's Title XIX agency.
- B. For covered inpatient organ transplant services an out-of-State hospital, excluding a D.C. hospital, shall be reimbursed the lesser of:
 - 1. The Medicare DRG rate;
 - 2. 70 percent of charges;
 - 3. The amount reimbursable by the host state's Title XIX agency.
- C. For inpatient services, a hospital licensed special-rehabilitation, except a hospital located in D.C., shall be reimbursed the lesser of its charges or:
 - 1. The amount reimbursable by the host state's Title XIX agency.
 - 2. If the host state's Title XIX agency does not cover inpatient rehabilitation hospital services, the amount reimbursable by the Title XVIII intermediary; or
 - 3. If the methodologies in 1 and 2 above are not applicable, the rate of reimbursement will be according to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR 413, or on the basis of charges if less than reasonable cost.

In calculating retrospective cost reimbursement rates, the Program or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, or groups of costs, or costs of specific groups of patients. When the cost, or group or groups of costs designated, cover services rendered to all patients, including MA recipients, operating costs applicable to all patients shall be reduced by the amount of the restricted grants, gifts, or income from endowments thus resulting in a reduction of allowable costs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

D. Out of State Psychiatric Hospitals

A hospital located outside of Maryland, but not in D.C., shall be reimbursed the lesser of its charges or the amount reimbursable by the host state's Title XIX agency.

TN: 18-0007

Approval Date: September 18, 2018

Effective Date: October 01, 2018

Supersedes TN: 11-14

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

- X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

See Attached Conditions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19A

- X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

See Attached Conditions

- X Additional Other Provider-Preventable Conditions identified below

(1) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(2) Reductions in provider payment may be limited to the extent that the following apply:

- (i) The identified provider-preventable conditions would otherwise result in an increase in payment.
- (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(3) A State plan must ensure that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Effective July 1st, 2011, Potentially Preventable Complications are identified based on the present on admission (POA) information on hospital discharge abstract data set submitted to HSCRC. MHAC scaling is determined by two components: a. incidence of complications b. amount of additional charges for each PPC. The incidence of complications is the count of each PPC included in the MHAC program adjusted for the patient mix using APR-DRG and SOI categories. This method calculates hospital's expected incidence of complications given the severity of its patients mix based on the defined performance criteria (state average in the previous year) and compares expected values to the observed incidence to scale the hospital's overall performance. The amounts of additional charges for each PPC are estimated using a state-wide regression analysis of standardized charges in the previous year, which controls for the admission APR-DRGs and SOIs. For each PPC, the overall impact is calculated as follows:

PPCi=Each of the PPCs included in MHAC

A=hospital's actual number of PPC

E=hospital's expected rate of PPC

RA=estimated additional charge of PPC based on state-wide regression estimate

$IMPACT_i = (APPC_i - EPPC_i) * RAPPC_i$

The sum of each individual PPC impact yields an overall additional resource use due to excess/low complication rates for each hospital. The MHAC hospital index is calculated as the overall additional resource use as a percentage of hospital revenue from cases that were included in the PPC determination.

Table 1: PPC Regression

Based on HSCRC FY 2011 Case Mix Data		Case #	CMS
PPC #	PPC Description		Corresponding HAC
1	Stroke & Intracranial Hemorrhage	1,005	
2	Extreme CNS Complications	542	
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	5,824	
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	949	
			Surgical Site Infections, Mediastinitis following CABG is a subset of PPC #5
5	Pneumonia & Other Lung Infections	4,470	
6	Aspiration Pneumonia	1,853	
			Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures is a subset of PPC 7
7	Pulmonary Embolism	623	
8	Other Pulmonary Complications	4,669	
9	Shock	2,010	
10	Congestive Heart Failure	2,071	
11	Acute Myocardial Infarction	1,280	
12	Cardiac Arrhythmias & Conduction Disturbances	1,119	
13	Other Cardiac Complications	316	
14	Ventricular Fibrillation/Cardiac Arrest	747	
15	Peripheral Vascular Complications Except Venous Thrombosis	266	
			Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures is a Subset of PPC 16
16	Venous Thrombosis	1,576	
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	786	
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	298	
19	Major Liver Complications	431	
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	458	
			Catheter-Associated Urinary Tract Infection is a subset of PPC 22
22	Urinary Tract Infection	5,665	
23	GU Complications Except UTI	496	
24	Renal Failure without Dialysis	8,069	
25	Renal Failure with Dialysis	215	
26	Diabetic Ketoacidosis & Coma	53	
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	1,191	
28	In-Hospital Trauma and Fractures	148	Falls and Trauma (see also PPC
29	Poisonings Except from Anesthesia	181	
30	Poisonings due to Anesthesia	1	
			Pressure Ulcer Stages III & IV is a subset of PPC 31
31	Decubitus Ulcer	1,063	
TN # 11-15 Approval Date APR - 3 2012 Effective Date JUL - 1 2011		Supersedes TN # NEW	

Table 1: PPC Regression

PPC #	PPC Description	Case #	CMS	Corresponding HAC
32	Transfusion Incompatibility Reaction	4		
33	Cellulitis	1,194		
34	Moderate Infectious	1,085		
35	Septicemia & Severe Infections	2,789		
36	Acute Mental Health Changes	766		
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1,246		
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	92		
39	Reopening Surgical Site	160		
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure	3,267		
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I	198		
42	Accidental Puncture/Laceration During Invasive Procedure	1,463		
43	Accidental Cut or Hemorrhage During Other Medical Care	112		
44	Other Surgical Complication - Mod	445		
45	Post-procedure Foreign Bodies	30		
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	2		
47	Encephalopathy	1,480		
48	Other Complications of Medical Care	755		
49	Iatrogenic Pneumothorax	963		
50	Mechanical Complication of Device, Implant & Graft	552		
51	Gastrointestinal Ostomy Complications	350		
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascula	1,163		
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters &	382		
54	Infections due to Central Venous Catheters	495		
56	Obstetrical Hemorrhage with Transfusion	508		
57	Obstetric Lacerations & Other Trauma Without Instrumentation	1,219		
58	Obstetric Lacerations & Other Trauma With Instrumentation	484		
59	Medical & Anesthesia Obstetric Complications	865		
60	Major Puerperal Infection and Other Major Obstetric Complications	289		
61	Other Complications of Obstetrical Surgical & Perineal Wounds	182		
62	Delivery with Placental Complications	248		

JUL - 1 2011

Effective Date

APR - 3 2012

Approval Date

TN # 11-15

Supersedes TN # NEW

- C. Additional payments will be made as determined in B. (above)
- D. Out-of-State hospitals will be paid a disproportionate share adjustment as determined by the host state.
 - (2) Out-of-State hospitals designated as national referral centers for non-experimental organ transplant will be reimbursed the lesser of the Medicare DRG rate, 70% of charges, or the amount reimbursable by the host State's Title XIX Agency, for covered organ transplants.
 - (3) An Out-of-State hospital which is reimbursed under a prospective reimbursement methodology using diagnosis related groups or under a cost related reimbursement methodology shall be reimbursed the lesser of its' charges or the amount reimbursable by the host State's Title XIX agency. There shall be no year-end cost settlement.
 - (4) Reserved
- E. Any redistribution of an overpayment for DSH shall first be redistributed within the same category of facility as the overpayment, i.e. Public Psychiatric Hospitals, Public Rehab Hospitals or Private General Hospitals. The redistribution shall be to all hospitals in the group who have not received the maximum for which they are eligible. The distribution shall be based on the percentage of each hospital's unused capacity to the total unused capacity for the category. If all available overpayments are not allocated in this manner the remaining categories shall be combined into one group and the remaining overpayment amount shall be based on the percentage of each hospital's available capacity to the total available capacity for all remaining hospitals.

TN 11-11

Supersedes

TN 95-13

Approval Date

SEP 23 2011

Effective Date

APR - 1 2011

RESERVED FOR FUTURE USE

TN 11-01
Supersedes
TN 94-10

Approval Date APR 15 2011

Effective Date

JAN - 1 2011

Reserve for Future Use

TN NO. 10-03
Supersedes TN No. 07-03

Approval Date: JUN 25 2010
Effective Date: JANUARY 1, 2010



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

WASHINGTON, D.C. 20201

87-3

JUN 6 1977

Neil Solomon, M.D., Ph.D.
Secretary
Maryland Department of Health
and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Dr. Solomon:

Your request for waivers for Title XIX under Section 222(b) Public Law 92-603 has been reviewed and approved. The pertinent citations for the waivers are: Section 1902(a)(13)(D) of the Social Security Act; 45 CFR 250.30(a)(2)(i)(ii) and (iii), and 45 CFR 250.30(b)(1). The waivers are granted for one year only. It will be necessary to submit a request for continuation to proceed beyond the one year. The waivers will become effective beginning July 1, 1977, and will end on June 30, 1978. The granting of the stated waivers for Title XIX will coincide with the beginning date of the waivers granted for Title XVIII by the Social Security Administration.

The experimental demonstration to be conducted in relation to these waivers is that contained in SSA Contract No. 600-76-0140 between your office and the Social Security Administration. That contract will now pertain in full to the Title XIX inclusion and all restrictions and conditions therein shall be likewise in effect, including the application of a CAP formula guaranteeing a limit to Title XIX program expenditures. The Federal project officer assigned shall develop any contract adjustments necessary to affect the inclusion of the Title XIX portion into that experimental demonstration contract.

RECEIVED

JUN 09 1977

Sincerely yours,

Robert A. Derzon
Administrator

cc: Regional Commissioner, Region III
Commissioner, Social Security Administration

ST. MD

SA Approved

9-28-81

RO Approved

11-2-81

Effective

7-1-81

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ADMINISTRATOR
WASHINGTON, D.C. 20201

82-3

OFFICE OF THE ADMINISTRATOR

Mr. Charles B. Buck, Jr., Sc.D.
Secretary
Department of Health and
Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Mr. Buck:

Your recent request for a 3-year waiver of Medicaid reimbursement principles has been approved under the authority of Section 402 of the Social Security Amendments of 1967 as amended by Section 222(b) of Public Law 92-603.

This approval permits the uninterrupted continuation of the hospital prospective rate setting experiment presently being conducted by the Maryland Health Services Cost Review Commission under Health Care Financing Administration (HCFA) Contract No. 600-76-0140. The waivers are subject to the following terms and conditions:

1. Any substantive change in the current rate setting methodology of the MHSCRC as the result of the developmental program shall be subject to the prior approval of HCFA before its application to participating hospitals.
2. Waivers for the inclusion of chronic disease hospitals in the demonstration are approved subject to final review and approval of the rate setting methodology by the HCFA project officer.
3. The present payor differential for Medicaid contained in HCFA Contract No. 600-76-0140 shall remain in effect until such time that the Commission submits justification for a revised differential and it is approved by the HCFA project officer.

RECEIVED

JUL 3 - 1980

DIRECTOR OF MANAGEMENT
AND FISCAL SERVICES

RECEIVED

Mr. MR 9-28-81
Approved 11-2-81 7-1-81

4. Since the Hill-Burton program is administered by the Health Resources Administration, the requested waiver of Hill-Burton charity care requirements cannot be approved by HCFA. The Commission may request a formal ruling from the Health Resources Administration as to whether a hospital may recover from its patient care revenues or other sources of income, the charity care costs it must incur because of the Hill-Burton assistance it received.
5. The MHSCRC will undertake a study of the ESRD treatments provided in Maryland to analyze the effects of the present reimbursement practices on the frequency of treatment, the level of treatment and the per patient maintenance and stabilization costs. MHSCRC will also prepare recommendations on alternative reimbursement systems for ESRD based on the results of the study. A workplan must be submitted to the HCFA project officer for approval by September 1, 1980.

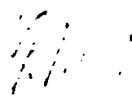
The provisions and restrictions of HCFA Contract No. 600-76-0140 including the CAP formula guaranteeing a limit on Medicaid expenditures shall remain in effect. Any modifications to the Commission's rate setting methodology must be incorporated into the contract.

Medicaid principles of reimbursement shall be waived with respect to hospitals participating in the experiment and receiving payment under the experimental methodology. During their periods of participation, such hospitals shall be paid for services furnished to Medicaid recipients according to experimental payment methodology developed and promulgated by the Commission and approved by the Health Care Financing Administration.

The waivers will be effective for a 3-year period beginning July 1, 1980 and ending June 30, 1983.

Your acceptance of the waivers as described herein is required in writing. If any of these issues require further discussion, please feel free to call on me or my staff.

Sincerely yours,


Earl M. Collier, Jr.
Acting Administrator

md

11-2-81

9-28-81

7-1-81

DEPARTMENT OF HEALTH & HUMAN SERVICES

Attachment 4.19-A & B
Health Care Financing Administration
Page 17 Revised 7/1/83

RECEIVED

JUL 7 1983

The Administrator
Washington, D.C. 20201

MEDICAL ASSISTANCE
POLICY ADMINISTRATION

88 JUN 1983

RECEIVED

JUN 30 1983

EXEC. DEPT.

The Honorable Harry Hughes
Governor of Maryland
Annapolis, Maryland 21404

Dear Governor Hughes:

Thank you for your letter of April 25, 1983, requesting a continuation of the existing Medicare and Medicaid hospital reimbursement waivers beyond June 30, 1983 for the State of Maryland. As you know, the recently enacted Social Security Amendments of 1983 will permit the Health Care Financing Administration to continue Medicare's participation in State administered hospital reimbursement control systems as a program activity rather than as a special demonstration project. The Maryland program will be the first hospital payment system to be considered for this new program waiver. The necessary regulations to implement section 1886(c) of the Social Security Act are now being drafted and will be issued in August 1983.

To permit the continuous operation of your hospital payment system and to assure a smooth transition to this new program, I am extending your present Medicare and Medicaid demonstration waivers under the authority of section 402 of the Social Security Amendments of 1967 until the regulations are promulgated for section 1886(c) and the State's system has been considered under this section. During this transition period, I have asked both my demonstration and program policy staffs to work very closely with the Maryland Health Services Cost Review Commission to assure that all the requirements of the new legislation are clearly understood.

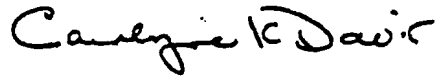
Several other major changes in Medicare policy have taken place since the award of our previous demonstration waivers. Two significant changes which directly affect the Maryland program are being implemented during this transition period. These are the new Medicare prospective payment rates for dialysis services which are effective August 1, 1983, and the Medicare hospital-based physician requirements which go into full effect on October 1, 1983. We expect these new requirements to go into effect in Maryland when you come under section 1886(c). As a result, we believe it is important for hospitals to begin now making the necessary adjustments to those requirements. Accordingly, I am granting the demonstration waivers for the transition period with conditions that call for the implementation of these new provisions. The full set of conditions to the waivers is enclosed.

Page 2 - The Honorable Harry Hughes

The waivers and the enclosed terms and conditions must be accepted in writing within 21 calendar days after the date of this letter by the Executive Director of the Maryland Health Services Cost Review Commission. The Secretary of the Maryland Department of Health and Mental Hygiene must also accept the Medicaid waivers in writing within the same time frame.

Please let me know if I can be of further assistance.

Sincerely yours,

A handwritten signature in cursive script that reads "Carolyn K Davis".

Carolyn K. Davis, Ph.D.

Enclosure

TERMS AND CONDITIONS

Medicare and Medicaid Waiver for the Continuation of the Maryland Hospital
Prospective Rate Setting Experiment beyond July 1, 1983

1. Medicare and Medicaid principles of reimbursement are to be waived with respect to hospitals participating in the experiment and receiving payment under the experimental methodology. During their periods of participation, such hospitals shall be paid for covered services furnished to Medicare and Medicaid patients according to payment methodologies developed and promulgated by the Health Services Cost Review Commission (HSCRC).
2. Any substantive change in the current rate setting procedures and methodologies of the HSCRC shall be subject to the prior approval of HCFA before its application to Medicare and Medicaid payments.
3. The provisions and restrictions of the present waivers including the CAP formula guaranteeing limits on Medicare and Medicaid expenditures shall remain in effect.
4. The Medicare and Medicaid 6 percent payor differential on HSCRC charges for hospital services rendered to Medicare and Medicaid patients will remain in effect for the duration of this waiver.
5. Medicare payment for services of hospital-based physicians will be made in accordance with the appropriate Medicare regulations implementing section 108 of P.L. 97-248, The Tax Equity and Fiscal Responsibility Act of 1982. The HSCRC should propose to HCFA for approval by August 1, 1983 their plan for implementing this provision including the reasonable compensation test for "Part A" physician services.
6. Medicare payment for outpatient renal dialysis and related physician and laboratory services shall be made in accordance with the appropriate Medicare regulations implementing section 2145 of the Omnibus Budget Reconciliation Act of 1981.



OFFICE OF THE SECRETARY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

201 WEST PRESTON STREET

BALTIMORE, MARYLAND 21201

Area Code 301

383-

TTY FOR DEAF: Balto. Area 383-7555; D.C. Metro 565-0451

Harry Hughes, Governor

Charles R. Buck, Jr., Sc.D. Secretary

July 14, 1983

Carolyme K. Davis, Ph.D.
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Davis:

This letter is to accept on behalf of the Maryland Medical Assistance Program the waiver and enclosed terms and conditions in your letter of June 28, 1983.

It is my understanding that Conditions 1 through 4 continue the existing agreement between the Maryland Health Services Cost Review Commission and the Health Care Financing Administration. Specifically, that agreement includes the provision that Medicaid is eligible for the working capital part of the differential and can take advantage of this feature by making prompt payments or by maintaining a working capital advance according to existing Commission regulations. Medicaid understands that it is free to forego that 2% discount by withdrawing its working capital advance.

While Condition 5 relates to Medicare, it is my belief that the avoidance of double payment for physician services is important for all payors and that equity requires the Commission to apply Condition 5 to all payors. I believe that the plan the Commission will submit to you shortly applies to all payors.

While the Medicaid Program has minimal responsibility for paying for outpatient renal dialysis, I anticipate that Medicaid, as well as the Maryland Kidney Commission and the Maryland Kidney Program - both of which are within

Carolyn K. Davis, Ph.D.
July 14, 1983
Page 2

the Department of Health and Mental Hygiene - shall act in such a way as to complement Medicare's policy as reflected in Section 2145 of the Omnibus Budget Reconciliation Act of 1981.

Sincerely,

CRB 7/14/83

Charles R. Buck, Sc.D.
Secretary of
Health and Mental Hygiene

CRB/ap

cc: Governor Harry Hughes
Adele Wilzack ✓
Commissioners
Harold A. Cohen

bcc: OS-CRU Official File, fifth floor, O'Connor Building
OS-CRU Reading File, fifth floor, O'Connor Building

CRB/HAC/ap
7/14/83

8. Reimbursement Methodology: STEPS Case Management

6/20/19
Time period was
superseded changing
from 12 to 9 months
(unknown date /
unknown TN).

1. Requests for payment of STEPS case management services rendered shall be submitted according to procedures established by the Department. Payment requests which are not properly prepared or submitted may not be processed, but returned unpaid to the provider.
2. Requests for payment shall be submitted on the form specified by the Department.
3. STEPS case management providers shall bill the program \$90 per participant for initial case management (only one unit of service may be reimbursed during the initial 60 days following the beginning of STEPS case management). Ongoing STEPS case management shall be reimbursed at the rate of \$15 per unit of service (only one unit of service may be reimbursed per month).
4. The Department may not pay for case management claims received by the Program for payment more than 9 months after the completed service date.
5. Claims for case management services completed on different dates and submitted on a single form shall be received by the Program within 9 months of the earliest completed service date.
6. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 9-month period, or within 60 days of rejection, whichever is later.
7. Payments shall be made only to a qualified STEPS case management provider.

TN No. 88-6
Supersedes
TN No. _____

Approval Date JUL 26 1987

Effective Date JUL 01 1987

Reimbursement Methodology - Early Intervention Services Case Management

1. Requests for payment of early intervention services case management shall be submitted by an approved EIS CM provider according to procedures established by the Department. The Department reserves the right to return to the EIS CM provider, before payment, all invoices not properly signed and completed.

2. The EIS CM provider shall submit a request for payment on the invoice form designated by the Department. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

- (a) Date or dates of service;
- (b) Participant's name and Medical Assistance number;
- (c) Provider's name, location and provider number; and
- (d) Nature, unit or units, and procedure code or codes of covered services provided.

3. EIS CM providers shall bill the Medical Assistance Program for the appropriate fee as specified in # 5 (c) below.

4. The Program will make no direct payment to recipients.

5. Payment shall be made:

- (a) Only to an EIS CM provider for covered services rendered to a participant, as specified in these amendments;
- (b) Only to one provider of early intervention services case management rendered to a participant during a billing period; and
- (c) According to the following fee-for-service schedule for early intervention services case management:

<u>Description</u>	<u>Fee Per Unit of Service</u>
1) Initial case management (Only one unit of service may be reimbursed per participant).	\$500
2) Ongoing case management (Only one unit of service per month may be reimbursed for a participant, after completion of initial case management).	\$150
3) Annual IFSP review (Only one unit of service may be reimbursed for a participant annually, for a total of two units per participant.)	\$275

Reimbursement Methodology for EPSDT Diagnostic and Treatment Related Services**A. Request for Payment.**

- (1) Requests for payment of EPSDT diagnostic and treatment services rendered and completed shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but shall be returned unpaid to the provider.
- (2) Requests for payment shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. A separate invoice shall be submitted for each participant. The completed form shall indicate the:
 - (a) Date or dates of service;
 - (b) Participant's name and Medical Assistance number;
 - (c) Provider's name, location, and provider number; and
 - (d) Nature, unit or units, and procedure code or codes of covered services provided.
- (3) Providers shall bill the Medical Assistance Program for the appropriate fee specified in Section C below.

B. Billing Time Limitations.

- (1) The Department of Health and Mental Hygiene shall not pay for claims received by the Medical Assistance Program for payment more than 9 months after the completed service date.
- (2) Claims for services completed on different dates and submitted on a single form shall be received by the Medical Assistance Program within 9 months of the earliest completed service date.
- (3) A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Medical Assistance Program within the original 9 month period, or within 60 days of rejection, whichever is later.

C. The following services are covered under this section of the State Plan when referred for diagnosis or treatment as a result of a full or partial EPSDT screen:

Medical or other remedial care provided by licensed practitioners (this includes chiropractic services delivered by a licensed chiropractor; nutrition counseling delivered by licensed nutritionists and dietitians; mental health counseling services delivered by a licensed clinical social worker; psychological testing and mental health counseling delivered by a licensed psychologist; mental health counseling delivered by a licensed nurse psychotherapist).

TN No. 93-12
Supersedes
TN No. 92-9

Approval Date OCT 12 1993 Effective Date FEB 01 1993

The rehabilitative services not included elsewhere in the State plan are: medical day care for medically fragile and technology dependent children and therapeutic nursery programs.

Rehabilitative services do not include the following: habilitation services; custodial care; personal care to assist children with activities of daily living; or respite for parents.

The reimbursement for the above services will be the lower of: (1) the provider's customary charge to the general public; or (2) the Department's fee schedule.

Reserve

Reimbursement Methodology – Service Coordination for Children with Disabilities

1. Requests for payment for the services covered under Service Coordination for Children with Disabilities must be submitted by an approved provider of Autism Waiver Service Coordination, according to the procedures established by the Medical Assistance Program.
 2. A provider shall submit a request for payment on the invoice form designated by the Department. A separate invoice shall be submitted for each participant. The completed form shall indicate:
 - (1) Date or dates of service;
 - (2) Participant's name and Medical Assistance Number;
 - (3) Provider's name, location, and provider number; and
 - (4) Nature, unit or units of service, and procedure code or codes of covered services provided.
 3. A unit of service for waiver initial assessment is defined as:
 - (a) a completed initial waiver plan of care, approved by MSDE and signed by the service coordinator, the waiver participant or the parent or parents of a minor child and all other members of the waiver multidisciplinary team; and
 - (b) the provision of all other necessary covered services.
 4. A unit of service for waiver ongoing assessment is defined as:
 - (a) at least one documented monthly contact by the waiver participant's service coordinator in person, by telephone, or through written progress notes with the waiver participant or parent;
 - (b) a quarterly visit to the waiver participant's residence, residential program, or day program, including at least one visit to the waiver participant's residence every 12 months; and
 - (c) the provision of all other necessary covered services.
 5. A unit of service for waiver reassessment is defined as:
 - (a) a completed waiver plan of care review, with revisions as necessary, which is approved by MSDE and signed by the service coordinator, the waiver participants or the parent or parents of a minor child, all other members of the waiver multidisciplinary team; and
 - (b) the provision of all other necessary covered services.
 6. The Department will make no direct payment to recipients.
-

7. Billing time limitations for services shall be the same as set forth in COMAR 10.09.36.
8. The provider shall bill the Department for the appropriate fee or fees specified in #9.
9. Payment shall be made:
 - (a) only to one qualified provider for covered waiver services rendered on a particular date of service to a participant; and
 - (b) according to the following fee-for-services schedule for waiver providers:

	Description	Fee Per Unit of Service
a.	Waiver initial assessment: No more than one unit of service may be reimbursed per waiver participant.....	\$500
b.	Waiver ongoing assessment: No more than one unit of service per month may be reimbursed for a waiver Participant.....	\$150
c.	Waiver reassessment: At most, four units of service may be reimbursed for a waiver participant in a 12-month period.....	\$275
10.	Service Coordination for Children with Disabilities is advisory in nature except for Autism Waiver Service Coordination.	
11.	A restriction may not be placed on a qualified recipient's option to receive the services covered under this regulation except that Autism Waiver Service Coordination as defined, is required for waiver eligible persons who choose to enroll in the Autism Waiver.	
12.	Only waiver participants may receive Autism Waiver Service Coordination.	

13. The Medical Assistance Program shall pay only one qualified provider for covered services rendered on a particular date of service to a participant and according to the following fee-for-services schedule for non-waiver providers:

Description	Fee Per Unit of Service
a. Initial Individualized Education Program (IEP). Only one unit of service may be reimbursed per participant.....	\$500
b. Ongoing Service Coordination. Only one unit of service per month may be reimbursed for a Participant.....	\$150
c. IEP Review: At most, three units of service may be reimbursed for a participant in a 12-month period.....	\$275
14. Payment may not be made for ongoing service coordination when, for the same month, payment is made to the provider for furnishing to the participant either: a. An initial IEP service; or b. An IEP review service.	
15. Reimbursement may not be made for these services if the participant is receiving a similar case management service under another Medical Assistance Program authority.	

Mental Health Rehabilitation Services Program
Reimbursement Methodology

Providers participating in the Mental Health Rehabilitation Services Program ("Rehabilitation Program") are reimbursed at fixed rates established by the Department of Health and Mental Hygiene as detailed in COMAR 10.21.25. This regulation limits reimbursements to Rehabilitation Program providers to the lesser of the amount billed to the Medical Assistance Program or the fee established in COMAR 10.21.25.

Reimbursements to licensed mental health professionals and Outpatient Mental Health Clinics (COMAR 10.21.20) providing Diagnostic and Therapeutic treatment Rehabilitation Services (COMAR 10.21.25.04) and additional treatment services (COMAR 10.21.25.05) are generally determined by an examination of three factors for services most commonly billed and reimbursed. These are the rates paid by Medicare for these services, the quantity of such services expected to be delivered, and the appropriation available to pay for these services. Based upon these considerations, rates are established as an approximate percentage of Medicare rates for similar services. Because of additional expertise and coordination efforts usually required in the diagnosis and treatment of severe emotional disturbance in children, an enhanced rate is offered for the treatment of children and adolescents.

Reimbursement for support services rendered by Psychiatric Rehabilitation Programs (10.21.21) are detailed in COMAR 10.21.25.08. At one time, fee for service rates were calculated using actual program costs and services provided. In order to promote flexibility and efficiency in service utilization, reimbursements based on a series of monthly case rates have been established. To establish these rates, patients were divided into four groups, including two groups living in State supported Residential Rehabilitation Programs (RRP) and two groups living in the community. Levels of service for individuals residing in RRP included those in beds with intensive supports and those in beds with general supports. Individuals living in community settings were divided into those living independently (i.e., either alone or with other individuals who were not legally responsible for their care) and those living with individuals who were legally responsible for their care. For each of these groups, mean monthly service utilization and reimbursements were calculated. Based on these calculations, the number of individuals in service at each level, and the amount of appropriation available to reimburse these services, monthly rates for each of the levels were established in February 2004.

TN No. 04-24

Supersedes

TN No. 96-8 Approval Date JUN 25, 2004 Effective Date FEB. 1, 2004

Reimbursement for treatment services offered by programs, including Mobile Treatment Programs (10.21.19), free standing Partial Hospitalization Programs (10.21.02), and Residential Crisis Programs (10.21.26) were determined by identifying costs associated with each type of program, summing the costs of the program, and dividing those costs by the number of days or months of patient care expected to be delivered with resources included in the cost calculations. Reimbursement rates for these services are detailed in 10.21.25.07.

Utilization Review Program

The Mental Hygiene Administration shall assure that all non-emergency services in the Specialty Mental Health System are subject to appropriate utilization review and management as detailed in COMAR 10.09.70.07.

TN No. 04-24

Supersedes

TN. No. New Approval Date JUN 25, 2004 Effective Date FEB. 1, 2004

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

State of Maryland

Introduction

Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

Payments for care or service will not exceed the amounts indicated in the following section below and participation in the program will be limited to providers of service who accept as payment in full the amounts so paid.

The Single State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on cost of providing care or service, or fee plus cost of materials.

Reimbursement Limitations:

- A. The Department may not reimburse the claims received by the Program for payment more than 12 months after the date of services.
- B. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:
 - (1) Approved, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and
 - (2) Denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.
- C. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 12 months of the earliest date of service.
- D. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 12 months period, or within 60 days of rejection, whichever is later.
- E. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 12 months of the date on which eligibility was determined.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19B.

- X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below

MD Does not pay for OPPC when they occur in settings under Attachment 4.19-B.

(1) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(2) Reductions in provider payment may be limited to the extent that the following apply:

- (i) The identified provider-preventable conditions would otherwise result in an increase in payment.
- (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(3) A State plan must ensure that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

TN # 11-15

Supersedes TN # NEW

Approval Date APR - 8 2012

Effective Date JUL - 1 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

**Physician and Certified Nurse Midwives/ Payment for Prenatal Risk Assessment
and Prenatal Education**

- a. The Program will reimburse for one Prenatal Risk Assessment at the beginning of a pregnancy. It must be furnished by a physician or certified nurse midwife and shall be reimbursed the lesser of the Medicaid rate of \$40 or the amount billed. Only one prenatal risk assessment will be reimbursed per pregnancy.
- b. The Program will reimburse for up to one unit of prenatal education at each prenatal visit. It must be furnished by a physician or certified nurse midwife or their extenders and shall be reimbursed the lesser of the Medicaid rate of \$10 or the amount billed.
- c. The Agency's rates related to 1.a and 1.b (above) were set as of July 1, 1989 and are effective for services on or after that date. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers.
- d. The Agency only pays for these services when the pregnant woman is not enrolled in a HealthChoice Managed Care Organization.

Tobacco Cessation Counseling Services for Pregnant Women

Maryland Medicaid pays for two types of services:

1. Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
2. Smoking tobacco use cessation counseling visit; intensive, greater than 10 minutes

These codes are used in conjunction with, but are distinct from, evaluation and management services. The providers bill for both the appropriate E&M and counseling visit when both are performed. The service cannot be billed more than once a day.

The department's fee schedule rate was set as of September 29th, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at:

health.maryland.gov/providerinfo

Except as otherwise noted in the Plan, State developed fee schedules are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the aforementioned website.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON
INSTITUTIONAL SERVICES****Reimbursement for Preventive Services: Doula Services****General Description:**

Doula services will be used to provide support for pregnant individuals throughout the perinatal period, which may improve birth-related outcomes. Pursuant to 42 C.F.R. Section 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

The Program covers up to eight perinatal visits and one labor and delivery service rendered during a birthing parent's prenatal period, labor and delivery, and postpartum period.

Each perinatal service visit will be billed for and reimbursed separately.

1. Prenatal visits are reimbursed at 15 minute increments.
2. Postpartum visits are reimbursed at 15 minute increments.
3. Both prenatal and postpartum visits have a maximum capacity of four (4) units per visit.
4. Reimbursement for attendance during delivery is set at a flat rate.

All doula providers are reimbursed pursuant to the same HCPCS codes and minimum rates found in the Maryland Provider fee schedule. A link to the published fee schedule can be found by going to the "Billing Guidance, Fee Schedules, and Preauthorization Information" section of Maryland Medicaid Provider Information page at <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx> and selecting the "Professional Services Fee Schedule" for the most recent year.

Limitations

1. One of the following providers shall be present while doula services are provided during the delivery:
 - a. An obstetrician-gynecologist;
 - b. A family medicine practitioner; or
 - c. A certified nurse midwife.
2. The Maryland Medical Assistance Program will not cover;
 - a. Expenses including:
 - i. Administrative overhead; or
 - ii. Ongoing certification, training, or consultation.

Reimbursement for Preventive Services: Doula Services

- b. Doula services rendered during labor and delivery as a telehealth visit; and
- c. Services that are not medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON
INSTITUTIONAL SERVICES****Reimbursement for Preventive Services: Home Visiting Services**

The home visiting services reimbursement timeframe is different depending on the evidence-based model in use. Each home visiting service will be billed for and reimbursed separately.

All home visiting service providers, both government and non-government, are reimbursed pursuant to the HCPCS codes and minimum rates found in the Maryland Medicaid Professional Services Fee Schedule. A link to the published fee schedule can be found by going to the “Billing Guidance, Fee Schedules, and Preauthorization Information” section of the Maryland Medicaid Provider Information page at health.maryland.gov/providerinfo and selecting the Professional Services Fee Schedule for the most recent year.

The state assumes different levels of need per family; it is assumed that different quartiles of participants will receive 4 visits per month, 3 visits per month, 2 visits per month, or 1 visit per month during their time engaged with home visiting services.

Healthy Families America (HFA)

Reimbursement for home visiting services is limited to HFA program sites who have received the designation of fully accredited by the HFA National Program Office. HFA sites offer at least one home visit per week for the first six months after the child's birth. After the first six months, visits might be less frequent. Visit frequency depends on families' needs and progress over time. Typically, home visits last one hour. There are no increments for HFA home visiting services. One home visit is the maximum capacity. Typically, participants receive one home visit a week. This may increase if cases of crisis occur and the HVS provider deems that the family requires an increase. Qualifying home visits will be reimbursed at the fee schedule amount per home visit.

Nurse Family Partnership (NFP)

Reimbursement for home visiting services is limited to NFP program sites who have received the designation of fidelity by the NFP National Program Office. NFP sites partner with their participants to determine the content and frequency of visits. Visit frequency is flexible and content is adapted to meet the needs of the client based on the client's strengths, risks, and preferences. Home visits typically last 60 to 75 minutes. The NFP program begins as early as possible in pregnancy, but not later than the end of the 28th week of pregnancy. Clients complete the program when the child turns 2 years old. There are no increments for NFP home visiting services. One home visit is the maximum capacity. Typically, participants receive one home visit a week. This may increase if cases of crisis occur and the HVS provider deems that

Reimbursement for Preventive Services: Home Visiting Services

the family requires an increase. Qualifying home visits will be reimbursed at the fee schedule amount per home visit

Limitations:

1. The Maryland Medical Assistance Program will not cover;
 - a. Expenses including:
 - i. Administrative overhead;
 - ii. Lactation consulting services; and
 - iii. Program start-up costs for evidence-based model accreditation, initial training, or consultation; or
 - b. Services that are not medically necessary

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

Remote Patient Monitoring

Effective for dates of service on or after January 1, 2018, reimbursement for Remote Patient Monitoring in accordance with services described in Attachment 3.1A page 9C-1 shall be paid at a monthly rate of \$125.00/month. Providers may bill up to 2 consecutive months of RPM per authorized participant.

Reimbursement for RPM is limited to:

1. Physicians;
2. Physician Assistants;
3. Nurse Practitioners; or
4. Home Health Agencies when a physician prescribes RPM.

Providers must receive prior authorization from the Department in order to bill for RPM services.

Limitations:

1. Provider may not bill for purchase, repair or removal of equipment necessary to facilitate RPM.
2. Home health agencies will only be reimbursed for remote patient monitoring when the service is ordered by a physician.
3. The Department will not pay for the remote patient monitoring equipment or the internet connections necessary to transmit the results to the provider's offices

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

1. Effective July 1, 2025, the service is covered using the service procedure code T1029 — on-site environmental lead inspection, per dwelling — at a rate of \$418.49. This rate is published on the Maryland Department of Health website at:

health.maryland.gov/providerinfo

1. Payment is limited to providers that are Lead Risk Assessors accredited by the Maryland Department of the Environment.
2. The Department will conduct post-payment audits to ensure that providers are not paid for testing environmental substances such as water or soil and pays:

Only when the child in the dwelling has a documented elevated blood lead level at or above 3.5 µg/dL, the current Maryland elevated blood lead level, or CDC blood lead reference level; whichever is lower.

OVERHEAD

Rent/Utilities –	\$ 34.20
Accounting, Audits and IT Support (5% of total salary and fringe)	\$ 11.98
Telephone charges –	\$ 14.40
Total Overhead/Case	\$ 60.58
2019 Uprate Difference	+\$15.49
EQUIPMENT AND OVERHEAD TOTAL	<u>\$ 117.55</u>

TIME, SALARY & FRINGE TOTAL	\$300.92
EQUIPMENT AND OVERHEAD TOTAL	\$117.55
TOTAL COST PER ENVIRONMENTAL INSPECTION	\$418.49 ¹

1. Effective September 1, 2019, the service is covered using the service procedure code T1029 – on-site environmental lead inspection, per dwelling – at a rate of \$418.49. This rate is published on the Maryland Department of Health website at:

health.maryland.gov/providerinfo

2. Payment is limited to providers that are Lead Risk Assessors accredited by the Maryland, Department of the Environment.
3. The Department will conduct post-payment audits to ensure that providers are not paid for testing environmental substances such as water or soil and pays:

Only when the child in the dwelling has a blood lead elevation ≥ 5 $\mu\text{g/dL}$

¹ Figures may not sum due to rounding.

Reimbursement for Preventive Services: Community Violence Prevention Services

General Description:

Community violence prevention services are delivered by a certified violence prevention professional. Medicaid participants who have been exposed to community violence or received treatment for an injury sustained as a result of an act of community violence are eligible for these services. Community violence prevention services are designed to promote improved health outcomes and prevent further violence. In accordance with 42 C.F.R. § 440.130(c), these services are recommended by a physician or other qualified licensed practitioner of the healing arts within the practitioner's scope of practice under state law and are designed to prevent further impacts of community violence, prevent future community violence, prolong life, and promote the physical and mental health of the individual.

The Program covers up to 100 units of community violence prevention services rendered to an eligible participant in a rolling 12 month period. Payments shall be made in 30-minute units of service.

All VP providers are reimbursed pursuant to the same CPT codes and minimum rates found in the Maryland Provider fee schedule. A link to the published fee schedule can be found by going to the "Billing Guidance, Fee Schedules, and Preauthorization Information" section of Maryland Medicaid Provider Information page at health.maryland.gov/providerinfo and selecting the "Professional Services Fee Schedule" for the most recent year.

Limitations:

Community violence prevention services are subject to the following limitations:

1. Maryland Medicaid does not cover:
 - a. Administrative overhead and ongoing certification or training; or
 - b. Services that are not medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Physician and Osteopath Rates

5.a All providers described in 5.b, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers are paid by CPT codes which are based on a percentage of Medicare reimbursement. Effective September 1, 2024, provider rates for covered Evaluation and Management (E&M) procedure codes within range of 99202-99499 were set between 93 to 100 percent of Medicare rates established January of each year. The rates are evaluated annually and adjusted as needed.

5.b The Department's original reimbursement methodology for professional services rendered by a physician or osteopath was set July 1st, 2015 and is effective for services rendered on or after that date. All providers must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. Providers will be paid the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. In addition, the State will pay the federally calculated VFC administration charge. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

5.c Effective August 1, 2022, when the federal government covers 100% of a vaccine's ingredient cost and where the Program has not established separate administration rate(s) for specific vaccines (e.g. monkeypox), the Program will provide reimbursement for vaccine administration for federally purchased vaccines to adults at the higher of:

- (1) The VFC administration rate; or
- (2) If applicable, 100% of the Medicare rate for the CMS-designated vaccine administration code for that vaccine.

5.d Professional services rendered by physicians to a trauma patient on the State Trauma Registry, who is receiving emergency room or inpatient services in a state designated trauma center, reimbursement will be 100 percent of the Baltimore City and surrounding area Title XVIII Medicare physician fee schedule facility fee rate. All providers must be licensed in the jurisdiction in which they provide services and must be providing services within a state designated trauma center. Services are limited to those outlined in 3.1A of the Maryland State Plan. The provider will be paid the lower of either the provider's customary fee schedule to the general public or the fee methodology described above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

- 5.e The Agency reimburses schools for psychiatric evaluations when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental providers as described in 5.b.
- 5.f Effective January 1, 2023, the reimbursement rate for treatment in place and mobile integrated health is set at \$150 per event. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of treatment in place and mobile integrated health services. These services are provided by emergency service transporters under supervision of a physician.

Treatment in Place:

Emergency service transport providers may be reimbursed for medically necessary services rendered to an individual without subsequent transportation when:

1. The emergency response system (9-1-1) is activated;
2. An ambulance is dispatched; and
3. At a minimum the provider administers a patient assessment

Mobile Integrated Health:

Emergency service transport providers will be reimbursed for medically necessary community-based preventative, primary, chronic, preadmission, or post admission health care services provided to a participant when the services are:

1. Within the scope of practice of the emergency medical services provider;
2. Provided in a home or another community-based setting to a program recipient who does not require emergency medical transport; and
3. Consistent with the protocols issued by the emergency medical services board.

5.g. Payment limitations:

- Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultants.
- Referrals from one physician to another for treatment of specific patient problems may not be billed as consultations.
- The operating surgeon may not bill for the administration of anesthesia or for an assistant surgeon who is not in his employ.
- Payment for consultations provided in a multi-specialty setting is limited by criteria established by the Department.
- The Department will not pay a provider for those laboratory or x-ray services performed by another facility but will instead pay the facility performing the procedure directly.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

- The Department will not pay physicians under their physician's provider number for services rendered by an employed non-physician extender, such as, a physical therapist, an occupational therapist, a speech language pathologist, an audiologist or a nutritionist.
- The Department will not pay for physician-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
 - o Completion of forms and reports;
 - o Broken or missed appointments;
 - o Professional services rendered by mail;
 - o Services which are provided at no charge to the general public;
 - o Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

Reimbursement Template -Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- ☒ The rates reflect all Medicare site of service ~~and locality adjustments.~~
- ☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- ☐ The rates reflect all Medicare geographic/locality adjustments.
- ☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:
Maryland received and is using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates. We do not plan to make any changes to the fee schedule this year.

Method of Payment

- ☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- ☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

- ☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- ☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

TN # 13-03
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Approval Date MAY 24 2013

Effective Date JAN 01 2013

See Attached page 4.19B Page 6B-3

(Primary Care Services Affected by the Payment Methodology – continued)

- ☒ The State will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added)
See Attached page 4.19B Page 6B-3

Physician Services – Vaccine Administration

For calendars years (CYs) 2013 and 2014 the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400 (a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

- ☐ Medicare Physician Fee Schedule rate
- ☒ State Regional maximum administration fee set by the Vaccines for Children program
- ☐ Rate using the CY 2009 conversion factor

Effective for dates of services on or after December 18, 2020 and continuing through the last day the federal government coverage the vaccine's ingredient cost, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

Effective August 1, 2022, when the federal government covers 100% of a vaccine's ingredient cost and where the Program has not established separate administration rate(s) for specific vaccines (e.g. monkeypox), the Program will provide reimbursement for vaccine administration for federally purchased vaccines to adults at the higher of:

- (1) The VFC administration rate; or
- (2) If applicable, 100% of the Medicare rate for the CMS-designated vaccine administration code for that vaccine.

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

- ☐ The inputted rates in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____.
- ☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code.

The current fee schedule is published on the Department's website at:
health.maryland.gov/providerinfo

- ☒ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: Maryland only pays a separate administration fee for VFC vaccines. It is our position that the provider is paid for non VFC vaccine administration through the appropriate office medical visit. Attached is a crosswalk of the appropriate VFC product codes (Attachment 4.19B: page 6B-4).

Note: The above section contains a description of the state's methodology and specifics on the affected billing codes.

Effective Date of Payment**E&M Services**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014.

Effective for dates of services on or after December 18, 2020 and continuing through the last day the federal government coverage the vaccine's ingredient cost, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

Effective August 1, 2022, when the federal government covers 100% of a vaccine's ingredient cost and where the Program has not established separate administration rate(s) for specific vaccines (e.g. monkeypox), the Program will provide reimbursement for vaccine administration for federally purchased vaccines to adults at the higher of:

- (1) The VFC administration rate; or
- (2) If applicable, 100% of the Medicare rate for the CMS-designated vaccine administration code for that vaccine.

The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Primary Care Services Affected by Payment Methodology: Attachment 4.19B Page 6B-3

No payments as of 7/1/2009 for these codes and no payments will be made under this SPA:

99339	99367	99401	99442	99489
99340	99366	99379	99412	99455
99358	99368	99380	99420	99456
99359	99374	99402	99441	99487
99360	99375	99403	99443	99488
99363	99377	99404	99444	99489
99364	99378	99411	99450	

Covered E&M Codes

Code	Date Added	Code	Date Added	Code	Date Added	Code	Date Added
99201	1/1/1992	99253	1/1/1992	99344	1/1/1998	99464	1/1/2009
99202	1/1/1992	99254	1/1/1992	99345	1/1/1998	99465	1/1/2009
99203	1/1/1992	99255	1/1/1992	99347	1/1/1998	99466	1/1/2009
99204	1/1/1992	99281	1/1/1992	99348	1/1/1998	99467	1/1/2009
99205	1/1/1992	99282	1/1/1992	99349	1/1/1998	99468	1/1/2009
99211	1/1/1992	99283	1/1/1992	99350	1/1/1998	99469	1/1/2009
99212	1/1/1992	99284	1/1/1992	99354	1/1/1994	99471	1/1/2009
99213	1/1/1992	99285	1/1/1992	99355	1/1/1994	99472	1/1/2009
99214	1/1/1992	99288	1/1/1992	99356	1/1/1994	99475	1/1/2009
99215	1/1/1992	99291	1/1/1992	99357	1/1/1994	99476	1/1/2009
99217	1/1/1994	99292	1/1/1992	99381	1/1/1992	99477	1/1/2008
99218	1/1/1993	99304	1/1/2006	99382	1/1/1992	99478	1/1/2009
99219	1/1/1993	99305	1/1/2006	99383	1/1/1992	99479	1/1/2009
99220	1/1/1993	99306	1/1/2006	99384	1/1/1992	99480	1/1/2009
99221	1/1/1992	99307	1/1/2006	99385	1/1/1992	99485	1/1/2013
99222	1/1/1992	99308	1/1/2006	99386	1/1/1992	99486	1/1/2013
99223	1/1/1992	99309	1/1/2006	99387	1/1/1992	99495	1/1/2013
99224	1/1/2011	99310	1/1/2006	99391	1/1/1991	99496	1/1/2013
99225	1/1/2011	99315	1/1/1998	99392	1/1/1992	99499	1/1/1992
99226	1/1/2011	99316	1/1/1998	99393	1/1/1992		
99231	1/1/1992	99318	1/1/2006	99394	1/1/1992		
99232	1/1/1992	99324	1/1/2006	99395	1/1/1992		
99233	1/1/1992	99325	1/1/2006	99396	1/1/1992		
99234	1/1/1998	99326	1/1/2006	99397	1/1/1992		
99235	1/1/1998	99327	1/1/2006	99406	1/1/2008		
99236	1/1/1998	99328	1/1/2006	99407	1/1/2008		
99238	1/1/1992	99334	1/1/2006	99408	1/1/2008		
99239	1/1/1996	99335	1/1/2006	99409	1/1/2008		
99241	1/1/1992	99336	1/1/2006	99429	1/1/1992		
99242	1/1/1992	99337	1/1/2006	99460	1/1/2009		
99243	1/1/1992	99341	1/1/1992	99461	1/1/2009		
99244	1/1/1992	99342	1/1/1992	99462	1/1/2009		
99245	1/1/1992	99343	1/1/1992	99463	1/1/2009		
99251	1/1/1992						
99252	1/1/1992						

TN # 13-03

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PRODUCT CODE	CROSSWALK TO	RATE
90371	90460	\$ 23.28
90633	90460	\$ 23.28
90645	90460	\$ 23.28
90647	90460	\$ 23.28
90648	90460	\$ 23.28
90649	90460	\$ 23.28
90650	90460	\$ 23.28
90655	90460	\$ 23.28
90656	90460	\$ 23.28
90657	90460	\$ 23.28
90658	90460	\$ 23.28
90660	90460	\$ 23.28
90669	90460	\$ 23.28
90670	90460	\$ 23.28
90680	90460	\$ 23.28
90681	90460	\$ 23.28
90696	90460	\$ 23.28
90698	90460	\$ 23.28
90700	90460	\$ 23.28
90702	90460	\$ 23.28
90707	90460	\$ 23.28
90710	90460	\$ 23.28
90713	90460	\$ 23.28
90714	90460	\$ 23.28
90715	90460	\$ 23.28
90716	90460	\$ 23.28
90718	90460	\$ 23.28
90721	90460	\$ 23.28
90723	90460	\$ 23.28
90732	90460	\$ 23.28
90734	90460	\$ 23.28
90743	90460	\$ 23.28
90744	90460	\$ 23.28
90748	90460	\$ 23.28

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON
INSTITUTIONAL SERVICES****Reimbursement for Preventive Services: Collaborative Care Model (CoCM)**

The Department establishes maximum allowable fees for Collaborative Care Model (CoCM) services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of CoCM services. The agency's fee schedule rates were set as of November 3, 2023 and are effective for services provided on or after that date.

Effective for dates of service November 3, 2023 and after, teams led by a qualifying primary care physician (as defined in Attachment 3.1A) of qualified professionals shall be eligible to receive reimbursement for psychiatric CoCM services. Providers may bill one 60-minute or 70-minute CPT code per month, and two additional 30-minute codes per month. Federally Qualified Health Centers may bill once per month, using a separate FQHC code.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Advanced Practice nursing reimbursement

6.a. Both government and non-government practitioners are reimbursed pursuant to the same fee schedule. All practitioners are paid by CPT codes which are based on a percentage of Medicare reimbursement.

6.b. The Agency's rates for professional services rendered by nurse practitioners, nurse midwives, and nurse anesthetists were set as of 7/1/2017 and are effective for services on or after that date. All practitioners must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The practitioner will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule, except as provided in 6.c. The average Maryland Medicaid payment rate is approximately 88 percent of Medicare 2015 fees. All rates are published on the Department's link below:

<https://health.maryland.gov/providerinfo>

6.c. Effective for dates of services on or after December 18, 2020 and continuing through the last day the federal government coverage the vaccine's ingredient cost, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

Effective August 1, 2022, when the federal government covers 100% of a vaccine's ingredient cost and where the Program has not established separate administration rate(s) for specific vaccines (e.g. monkeypox), the Program will provide reimbursement for vaccine administration for federally purchased vaccines to adults at the higher of:

- (1) The VFC administration rate; or
- (2) If applicable, 100% of the Medicare rate for the CMS-designated vaccine administration code for that vaccine.

6.d. Payment limitations:

- The Department will not pay for practitioner administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay a provider for

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedures directly.

- In addition, for nurse anesthetists preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the nurse anesthetist may not bill them as consultants.
- The provider may not bill the Program for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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State of Maryland

Physician Assistant Rates

- 8.a The Department's original reimbursement methodology for professional services rendered by physician assistants was developed as of July 1, 2015 and is effective for services rendered on or after that date. All physician assistants must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The physician assistant will be paid the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule.
- 8.b Both government and non-government physician assistants are reimbursed pursuant to the same fee schedule. All physician assistants are paid using CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. In addition, the state will pay the federally calculated VFC administration charge, except as provided in 8.c. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

- 8.c. Effective for dates of services on or after December 18, 2020 and continuing through the last day the federal government coverage the vaccine's ingredient cost, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

Effective August 1, 2022, when the federal government covers 100% of a vaccine's ingredient cost and where the Program has not established separate administration rate(s) for specific vaccines (e.g. monkeypox), the Program will provide reimbursement for vaccine administration for federally purchased vaccines to adults at the higher of:

- (1) The VFC administration rate; or
- (2) If applicable, 100% of the Medicare rate for the CMS-designated vaccine administration code for that vaccine.

- 8.d Payment limitations:

- The Department will not pay for physician assistant administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay a provider for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
- The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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Certified Nurse Mid-wife Rates

- 7.a All certified nurse midwives, both government and non-government are reimbursed pursuant to the same fee schedule. Certified nurse midwives are paid by CPT codes which are based on a percentage of Medicare reimbursement. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 were set at 100% using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates.
- 7.b The Agency's rates for professional services rendered by a certified mid-wife were set as of 7/1/15 and are effective for services on or after that date. All nurse midwives must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The certified nurse midwife will be paid the lower of the certified nurse midwife's customary fee schedule to the general public or the published fee schedule. The average Maryland Medicaid payment rate is approximately 88 percent of Medicare 2015 fees. All rates are published on the Agency's website at:
dhmh.maryland.gov/providerinfo
- 7.c Payment limitations:
- The Department will not pay for practitioner administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
 - The Department will not pay for disposable medical supplies usually included with the office visit.
 - The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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State of Maryland

Podiatrist Rates

8.a All podiatrists, both government and non-government are reimbursed pursuant to the same fee schedule. Podiatrists are paid by CPT codes which are based on a percentage of Medicare reimbursement. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 were set at 100 percent using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates.

8.b The Department's reimbursement methodology for professional services rendered by a podiatrist was developed as of July 1, 2015 and is effective for services rendered on and after that date. All podiatrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The podiatrist will be paid the lower of either the podiatrist's customary fee schedule to the general public or the published fee schedule, except as described in 8.c. The average Maryland Medicaid payment rate is approximately 79.5 percent of Medicare 2017 fees. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

8.c Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

8.d Payment limitations:

- Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultations.
- Referrals from one podiatrist to another for treatment of specific patient problems may not be billed as consultations.
- The operating podiatrist may not bill for the administration of anesthesia or for an assistant podiatrist who is not in his employ.
- Payment for consultations provided in a multi-specialty setting is limited by criteria established by the Department.
- The Department will not pay a podiatrist for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
- The Department will not pay for provider-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit. x The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
 - o Completion of forms and reports;
 - o Broken or missed appointments;
 - o Professional services rendered by mail or telephone;
 - o Services which are provided at no charge to the general public; and
 - o Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

RESERVE FOR FUTURE USE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Physical Therapist Rates

- 9.a The Department's reimbursement methodology for professional services rendered by a physical therapist was set as of July 1, 2017 and is effective for services rendered on or after that date. All physical therapists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The physical therapist will be paid the lower of either the physical therapist's customary fee schedule to the general public or the published Medicaid fee schedule.
- 9.b All physical therapists, both government and non-government, are reimbursed pursuant to the same fee schedule. Physical therapists are paid using CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 72.5 percent of Medicare 2017 fees. The current fee schedule is published on the Department's website at:
health.maryland.gov/providerinfo
- 9.c The Department reimburses schools for physical therapy evaluations, re-evaluations, and individual physical therapy sessions when required under an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) and when provided by physical therapists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for these services at the same rates that it reimburses all other non-governmental community-based licensed physical therapists as described in 9b.
- 9.d Payment limitations:
- The Department will not pay for disposable medical supplies usually included with the office visit.
 - The Department will not pay for services which do not involved direct, face to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY
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10. Dentist Rates

10.a. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services. The agency's fee schedule rate was set as of July 1, 2022 and is effective for services provided on or after that date. All rates are published on the Department's website at:

health.maryland.gov/providerinfo under the header "Dental and Laboratory Information".

Effective July 1, 2022, payments for Dental services to the Community as defined per Section 3.1A, shall be paid on a fee-for-service schedule.

10.b. Effective for dates of services on or after December 18, 2020 and continuing through the last day the federal government covers the vaccine's ingredient cost, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

10.c. Payment limitations:

- The Department will not pay for drugs administered by dentists that have been obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The provider may not bill for the Program or the participant for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone; and
 - Providing a copy of a participant's medical record when requested by another licensed provider on behalf of a participant.

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Optometrist Rates

- 11.a The Department's reimbursement methodology for professional services rendered by an optometrist were set as of July 1st, 2010 and is effective for services on or after that date. All optometrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The optometrist will be paid the lower of the optometrist's customary fee schedule unless it is free to individuals not covered by Medicaid or the published fee schedule.
- 11.b All optometrists, both government and non-government, are reimbursed pursuant to the same fee schedule. Optometrists are paid based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

- 11.c Payment limitations:
- The Department will not pay for practitioner-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
 - The Department will not pay for disposable medical supplies usually included in the office visit.
 - The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - o Completion of forms and reports;
 - o Broken or missed appointments;
 - o Professional services rendered by mail or telephone;
 - o Providing a copy of a recipient's medical record

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

4. Reimbursement Methodology for Mental Health Case Management

- 4.a Effective September 1st, 2009, payments shall be made with the fee-for-service schedule for mental health case management services specified in 4c. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

- 4.b "Unit of service" means a face-to-face contact for a minimum of one hour per day by the community support specialist of the community support specialist associate with the participant or, if the participant is a minor, the minor's parent or guardian. Mental health case management services are only performed by providers that meet the criteria outlined per Attachment 3.1A, Section E. Services shall be provided according to the following:
- a. Level 1 – General: A minimum of one and a maximum of two units of service each month. At a minimum, every 90 days, one service shall include a visit to the participant's home or another suitable site for a participant who is homeless.
 - b. Level II – Intensive: A minimum of two and a maximum of five units of service each month. At a minimum, every 90 days, one service shall include a visit to the participant's home or another suitable site for a participant who is homeless.
 - c. One additional unit of service above the monthly maximum may be billed during the first month of service to a participant in order to complete the comprehensive assessment.
- 4c. Rate development – The rate for this service follows the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on the average of the mileage of current case management providers who receive state general funds for case management.
- 4d. Case management services shall not be reimbursed for individuals in public institutions, IMDs, juvenile detention centers or PTRFs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

4. Reimbursement Methodology for Mental Health Case Management: Care Coordination for Children

- 4a. Effective, October 1, 2014, payment shall be made with the fee-for-service schedule mental health care management services specified in 4c. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

- 4b. "Unit of service" means 15 minutes of contact, which may include face-to-face and non-face-to-face contacts with the participant, or if the participant is a minor, the minor's parent or guardian, and indirect collateral contact on behalf of the participant with other community providers. Services shall be provided according to the following:
- 1) Level I – General Coordination allows a maximum of 12 units of service per month with a minimum of two units of face-to-face contact.
 - 2) Level II – Moderate Care Coordination allows a maximum of 30 units of service per month, with a minimum of four units of face-to-face contact.
 - 3) Level III – Intensive Care Coordination allows a maximum of 60 units of service per month, with a minimum of six units of face-to-face contact.
 - 4) For Level I and Level II four additional units of service above and beyond the monthly maximum may be billed during the first month of service to the participant and every six months thereafter to allow for comprehensive assessment and reassessment of the participant.
 - 5) A unit of service for telephonic contact may not be reimbursed unless the provider has delivered at least eight minutes of service.
- 4c. Rate development – The rate for the mental health case management care coordination for children and youth was developed following CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs.
- 4d. Reimbursement shall not be made for care coordination services if the participant is receiving a comparable care coordination service under another Program authority; the direct delivery of an underlying medical, educational, social, or other service to which a participant has been referred; activities integral to the administration of foster care programs; activities not consistent with the definition of case management services under Section 6052 of the federal Deficit Reduction Act of 2005 (P.L. 109-171); activities for which third parties are liable to pay; and activities delivered as part of institutional discharge planning. A participant's care coordinator may not be the participant's family member or a direct service provider for the participant.

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Mental Health Case Management

The Department's reimbursement methodology for Mental Health Case Management was set as of July 1st, 2013 and is effective for services on or after that date. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers.

Updated rates are included on the current fee schedule which is published on the Department's website at:

health.maryland.gov/providerinfo

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Reimbursement Methodology for HIV Targeted Case Management Services

1. 1. The reimbursement methodology was set on February 1, 2012 and is effective for services on or after that date. HIV targeted case management, including diagnostic evaluation services (DES) and ongoing case management services are paid as outlined in MD fee-for-service schedule. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both government and nongovernmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

2. HIV targeted case management services rendered shall be submitted by an approved provider according to procedures established by the Maryland Department of Health, and as outlined in the MD State Plan, Supplement 3 to Attachment 3.1A, page 4. Payment requests which are not properly prepared or submitted may not be processed, but will be returned unpaid to the provider.
3. A Diagnostic Evaluation Services (DES) "unit of service" is the completion of the bio-psychosocial assessment and plan of care including signatures of all members involved. Reimbursement is paid using a flat rate to the DES provider for completion of the bio-psychosocial assessment and plan of care.
4. An Ongoing Case Management "unit of service" is a 15-minute period in which ongoing case management services were provided. An ongoing case manager participating in the DES process, when not a representative of the DES provider, may be bill up to six units for his or her involvement in the DES process. Ongoing case management, as prescribed in the plan of care, shall be reimbursed up to 96 units of service per year following the date of service for diagnostic evaluation services.

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Behavioral Health Crisis Services
Reimbursement Methodology

1.
 - A. The Department's reimbursement methodology for behavioral health crisis services is a fixed rate. Rates were set as of January 1, 2024 and are effective for services on or after that date. Providers are reimbursed for behavioral health crisis services in accordance with services described in Attachment 3.1A Page 29C-53&54.
 - B. All providers, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule. The fee schedule for behavioral health crisis services providers is reviewed for updating every state fiscal year as determined by State of Maryland legislation. A link to the published fee schedule can be found by going to the Behavioral Health Information section of <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>, and clicking on the "PBHS Fee Schedule."

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Community-Based Substance Use Disorder Services

Reimbursement Methodology

1.
 - A. The Department's reimbursement methodology for community-based substance use disorder services is fixed rate. Rates were set as of April 4th, 2017 and are effective for services on or after that date. All providers must be licensed by the designated state agency to provide SUD treatment services and shall meet the requirements established by the Department. Services are limited to those outlined in 3.1.A Section 13d.V of the Maryland State Plan. Providers will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule.
 - B. Rates for peer recovery support services were set as of June 1, 2023 and are effective for services on or after that date.
 - C. All providers described in 1a, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers are paid by HCPCS codes and the rates are based on the rate that Maryland Medicaid reimburses its specialty mental health providers for similar services. The fee schedule for community-based substance use disorder providers is reviewed for updating every state fiscal year as determined by state of Maryland legislation. A link to the published fee schedule can be found by going to the Behavioral Health Information section of <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>, clicking on the "PBHS Fee Schedule," and selecting "PBHS SUD Fee Schedule."

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1905(a)(29) Medication-Assisted Treatment (MAT)

Reimbursement Methodology

1.
 - A. The Department's reimbursement methodology for community-based opioid use disorder (OUD) services is a fixed rate. Rates were set as of April 4th, 2017 and are effective for services on or after that date. All providers must be licensed by the designated state agency to provide OUD treatment services and shall meet the requirements established by the Department. Services are limited to those outlined in Supplement to Attachment 3.1A for 1905(a)(29). Providers will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule. Effective October 1, 2020 the state assures that medication assisted treatment (MAT) to treat opioid use disorder (OUD) as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.
 - B. Rates for peer recovery support services were set as of June 1, 2023 and are effective for services on or after that date.
 - C. Reimbursement for unbundled MAT prescribed drugs and biologicals used to treat opioid use disorder (OUD) is reimbursed in accordance with the reimbursement methodologies for covered outpatient legend and non legend drugs found in Attachment 4.19-B, pages 35-35a, Section A for both dispensed and administered prescribed drugs.
 - D. All providers described in 1a, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers are paid by HCPCS codes and the rates are based on the rate that Maryland Medicaid reimburses its specialty mental health providers for similar services. The fee schedule for community-based substance use disorder providers is reviewed for updating every state fiscal year as determined by state of Maryland legislation. A link to the published fee schedule can be found by going to the Behavioral Health Information section of health.maryland.gov/providerinfo, clicking on the "PBHS Fee Schedule," and selecting "PBHS SUD Fee Schedule."

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Nutritionist Rates

- 12.a. The Department's reimbursement methodology for professional services rendered by a nutritionist was set as of July 1st, 2010 and is effective for services on or after that date. All nutritionists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The nutritionist will be paid the lower of the nutritionist's customary charge to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.
- 12.b. All nutritionists, both government and non-government, are reimbursed pursuant to the same fee schedule. Nutritionists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:
- health.maryland.gov/providerinfo
- 12.c. The Department reimburses schools for nutritional assessments and interventions and nutritional reassessments and interventions when required under an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) and when provided by nutritionists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based licensed nutritionists as described in 12.b.
- 12.d. Payment limitations:
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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Occupational Therapist Rates

- 13.a The Department's reimbursement methodology for professional services rendered by an occupational therapist was set as of July 1st, 2010 and is effective for services on or after that date. All occupational therapists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The occupational therapist will be paid the lower of the occupational therapist's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.
- 13.b All occupational therapists, both government and non-government, are reimbursed pursuant to the same fee schedule. Occupational therapists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:
- health.maryland.gov/providerinfo
- 13c. The Department reimburses schools for occupational therapy evaluations and re-evaluations, individual occupational therapy sessions, and group occupational therapy when required under an Individualized Education Program (IEP) or Individual Family Services Plan (IFSP) and when provided by occupational therapists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1st, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based licensed occupational therapists as described in 13.b.
- 13.d Payment limitations:
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - o Completion of forms and reports;
 - o Broken or missed appointments;
 - o Professional services rendered by mail or telephone; and
 - o Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient.

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Speech Therapist Rates

- 14.a The Department's reimbursement methodology for professional services rendered by a speech-language pathologist was set as of July 1st, 2010 and is effective for dates of services on or after that date. All speech-language pathologists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The speech-language pathologist will be paid the lower of the speech-language pathologist's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.
- 14.b All speech-language pathologists, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Speech-language pathologists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:
- health.maryland.gov/providerinfo
- 14.c The Department reimburses schools for speech/hearing evaluation, individual speech therapy, and group speech therapy when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by speech-language pathologists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based speech-language pathologists as described in 14b.
- 14.d Payment limitations:
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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Audiologist Rates

- 15.a The Department's reimbursement methodology for professional services rendered by an audiologist was set as of July 1st, 2017 and is effective for dates of services on or after that date. All audiologists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The audiologist will be paid the lower of the audiologists customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.
- 15.b All audiologists, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Audiologists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:
- health.maryland.gov/providerinfo
- 15.c The Department reimburses schools for audiology evaluations when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by audiologists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based audiologists as described in 15b.
- 15.d Payment limitations:
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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16. Therapeutic Behavioral Aide Rates

- 16.a The Department's reimbursement methodology for one-on-one therapeutic behavioral aide services performed by therapeutic behavioral aides was set as of January 1st, 2010 and is effective for services on or after that date. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The therapeutic behavioral aide will be paid the lower of the therapeutic behavioral aide's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.
- 16.b All therapeutic behavioral aides, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Therapeutic behavioral aides are paid a fixed amount per each 15 minute increments. The current fee schedule is published on the Department's website within the Behavioral Health Administrative Service Organization:
- health.maryland.gov/providerinfo
- 16.c The Department reimburses schools for therapeutic behavioral aide services when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by a qualified therapeutic behavioral aide provider. For all dates beginning January 1st, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental therapeutic behavioral aides as described in 16b.
- 16.d Payment limitations:
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - o Completion of forms and reports;
 - o Broken or missed appointments;
 - o Professional services rendered by mail or telephone; and
 - o Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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17. EPSDT – Private Duty Nursing and Other Licensed Practitioners

- 17.a The Department reimburses private duty nursing agencies for an initial assessment fee and supervisory visit. All other private duty nursing services are paid fixed amount per 15 minute intervals depending on whether the provider is serving one or more children. The rates are specified in the established and published fee schedule. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of private duty nursing, CAN/CMTs, and HHA/CMTs. The Department's fee schedule rate was set as of March 1st, 2014 and is effective for services provided on or after that date. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

- 17.b The Department reimburses schools for private duty nursing services when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by a qualified private duty nursing provider. The State will reimburse for this service at the same rate that it reimburses all other non-governmental private duty nursing providers in accordance with 17a and 17b.
- 17.c Payment limitations:
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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Licensed Behavior Analysts

19a. The Department's reimbursement rate for Applied Behavioral Analysis (ABA) services, as defined in Attachment 3.1A Page 19-11C, is effective for dates of service on or after April 1st, 2018. The Department shall provide reimbursement to licensed behavior analysts who are enrolled in the Department and in good standing with the Behavior Analyst Certification Board (BACB).

19b. All governmental and non-governmental providers are reimbursed pursuant to the same fee schedule. Providers are paid according to the rates listed for the corresponding CPT codes that are based on rates set by Maryland Medicaid. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

19c. Reimbursement shall only be made for services preauthorized by the Medicaid Program or its designee.

19d. Payment limitations. The provider may not bill the Program or participant for:

- 1) Services that are:
 - i. Provided to an individual 21 years of age or older;
 - ii. Provided in a hospital, an institution for mental disease, an ICF-IID, a crisis residential program, a residential treatment center, a 24-hour, 365-day residential program funded with federal, State, or local government funds, or nonconventional settings;
 - iii. Rendered when measurable functional improvement or continued clinical benefit is not met, and treatment is not deemed necessary;
 - iv. Not preauthorized by the Department or its designee;
 - v. Not delivered in accordance with the participant's treatment plan;
 - vi. Not medically necessary;
 - vii. Beyond the provider's scope of practice;
 - viii. Rendered but not documented in accordance to COMAR 10.09.28.04; or
 - ix. Rendered by mail or telephone;
- 2) Services whose purpose is vocationally based or recreationally based;
- 3) Respite services;
- 4) Custodial care;
- 5) Completion of forms and reports;
- 6) Broken or missed appointments;
- 7) Travel to and from site of service; and
- 8) Services which duplicate a services that a participant is receiving under another medical care program.

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Program/Service

Pharmacists Rates

The Department's original reimbursement methodology for professional services rendered by pharmacists was developed as of January 1, 2019 and is effective for services rendered on or after that date. All pharmacists must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their lawful scope of practice in Maryland. The pharmacists will be paid at the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule, except for administration of COVID-19 vaccinations. Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

1. Equivalent to the Medicare rate for any single dose vaccine; and
2. When two or more doses are required and administered through a pharmacy provider, each dose administration shall be paid for at a rate equivalent to the sum of the total Medicare reimbursement for all doses divided by the total doses needed. For example, if two doses are required, reimbursement would be set according to the following formula: $\text{Reimbursement Rate} = (\text{Medicare Dose 1 reimbursement rate} + \text{Medicare Dose 2 reimbursement rate})/2$.

Both government and non-government pharmacists are reimbursed pursuant to the same fee schedule. All pharmacists are paid using CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. The current fee schedule is published on the Department's website at:

[Health.maryland.gov/providerinfo](https://health.maryland.gov/providerinfo)

Program limitations:

- The Department will not pay for pharmacists administered drugs obtained from manufacturers who do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included in the office visit.
- The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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RESERVE FOR FUTURE USE

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RESERVE FOR FUTURE USE

TN # 11-12
Supersedes TN # 10-04 Approval Date FEB 03 2012 Effective Date JULY 1, 2011

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18. Licensed Mental Health Practitioners:

- **Licensed Registered Nurse Practitioner with a specialty in Psychiatry**
- **Licensed Advanced Practice Registered Nurse certified in Psychiatric Mental Health**
- **Licensed Clinical Professional Counselor and Therapist**
- **Licensed Psychologist**
- **Licensed Clinical Social Worker**
- **Licensed Clinical Professional Art Therapist**

- 18a. The Department reimburses practitioners identified as “mental health professionals” differentially dependent on their licensure class. The professionals eligible for reimbursement are licensed under State law and include nurse psychotherapists, licensed doctoral psychologists, licensed and certified social workers, licensed and certified professional counselors, and certified nurse practitioners. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan.
- 18b. Maryland bases the rates on market factors, primarily comparable rates from other insurers. For each class of mental health professional and for each CPT procedure code, rates paid by other insurers are reviewed. Since Maryland reimburses for a broader range of services than many insurers, some adjustments and interpolations are required. In order to establish rates for similar procedures, rates are adjusted based upon time and intensity of effort required for the procedure in question. Whenever possible, rates are then benchmarked against Medicare rates for similar procedure codes. On average, State rates are below allowable Medicare rates. The Department’s reimbursement methodology was set on July 1st, 2008 and is effective for services provided on or after that date. Except as otherwise noted in the Plan, rates are the same for both governmental and private individual practitioners. Updated rates are included on the current fee schedule which is published on the Department’s website at: health.maryland.gov/providerinfo.
- 18c. The Department reimburses schools for certain mental health services when required under an Individual Education Program (IEP) or Individual Family Service Plan (IFSP) and when provided by a licensed mental health provider. These services include: individual psychotherapy, family psychotherapy, group psychotherapy, and psychological testing. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental mental health providers as described in 18b.
- 18d. Effective January 1, 2025, the Department reimburses schools for mental health services within the provider’s scope of practice for recipients who do not have an IEP or IFSP and when provided by licensed and certified social workers ..

Preauthorization:

The Department may provide an exception to the first limitation rule above if it, or its agent, finds the additional service is medically necessary, not duplicative.

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18e. Payment limitations:

- The Department will not pay for services which do not involve direct patient contact.
- The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail;
 - Services which are provided at no charge to the general public with the exception of certain mental health services that are rendered in the school setting to eligible recipients ; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.
- The Department reimburses only for one service per service date.
- The Department does not reimburse for outpatient health services provided to an individual when the individual is in a hospital or residential treatment center
- The Department does not reimburse services provided by a school health-related service provider that are not included on a child's IEP or IFSP, with the exception of certain mental health services described in 18.d

c. Home Health Agencies – reimbursed at the lower of the provider's customary charge to the general public or the Department's fee schedule. Effective January 1, 2010, the fee schedule rates shall be adjusted annually, by the same factor used by the Centers for Medicare and Medicaid Services in updating Medicare's prospective payment system rates. The annual fee schedule rate adjustment shall be limited to a maximum of 5 percent and be effective the date on which Medicare's rate changes are implemented. There are both governmental and private providers of home health services. All providers are reimbursed according to the same published fee schedule and will be notified of the rate change via transmittal which will also be published on the Department of Health and Mental Hygiene's web site.

TN 10-03
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Ambulatory Surgery Rates

A. Reimbursement Methodology:

- 1) Reimbursement fees equal 80 percent of the Medicare-approved ASC facility fee for services other than dental services furnished to Medicaid recipients in connection with covered surgical procedures.
- 2) The facility fee for dental services performed in a Medicare-approved ASC is reimbursed in accordance with the current fee schedule published on the Department's website at:

health.maryland.gov/providerinfo
- 3) If one covered surgical procedure is furnished to a recipient, payment is at the Maryland Medicaid Program payment amount which is 80 percent of the Medicare approved facility fee for that procedure.
- 4) If more than one covered surgical procedure is provided to a recipient in a single operative session, payment is made at 100 percent of the Maryland Medicaid Program payment amount for the procedure with the highest reimbursement rate. Other covered surgical procedures furnished in the same session are reimbursed at 50 percent of the Maryland Medicaid Program payment amount for each of those procedures.
- 5) When a covered surgical procedure is terminated before the completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicaid Program payment amount is based on one of the following:
 - a. If the procedure for which the anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started; the reimbursement amount is 80 percent of the Medicare approved facility fee;
 - b. If the procedure for which anesthesia is planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed, but before the anesthesia is induced; the reimbursement amount is 50 percent of the Medicare approved facility fee; or
 - c. If a covered surgical procedure for which anesthesia was not planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed; the reimbursement is 50 percent of the Medicare approved facility fee.
- 6) Practitioners bill directly for services in accordance with the Physicians Fee Schedule and the Dental Fee Schedule. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

- B. Reimbursement by the Program is for facility services provided by a free-standing ambulatory surgical center in connection with covered surgical procedures, include but are not limited to:
- 1) Nursing, technician, and related services;
 - 2) Use of the facility;

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- (3) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances, and any equipment directly related to the provision of surgical procedures;
 - (4) Administrative costs;
 - (5) Materials including supplies and equipment for the administration and monitoring of anesthesia;
 - (6) Radiology services for which separate payment is not allowed and other diagnostic tests or interpretive services that are integral to a surgical procedure;
 - (7) Supervision of the services of a nurse anesthetist by the operating surgeon; and
 - (8) Ancillary items and services that are integral to a covered surgical procedure as defined in 42 CFR §416.166.
- C) The Program may not bill for:
- (1) Completion of forms and reports;
 - (2) Broken or missed appointments;
 - (3) Professional services rendered by mail or telephone;
 - (4) Services which are provided at no charge to the general public;
 - (5) Direct payment to a recipient; and
 - (6) Separate direct payment to any person employed by or under contract to any free-standing Medicare-certified ambulatory surgical center facility for services covered under this regulation.
- D) The Program shall authorize payment on Medicare claims only if:
- (1) The provider accepts Medicare assignment; and
 - (2) Medicare makes direct payment to the provider.
- E) The Department pays 100% of Medicare deductibles and co-insurance and services not covered by Medicare, but considered medically necessary by the Program, according to the limitations of Regulation .04C of this chapter.
- F) Recovery and reimbursement under this chapter are set forth in COMAR 10.09.36.07.

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Specific Payment Procedures for Provider-Based Outpatient Oncology Facilities

- A. The provider shall submit a request for payment in the format designated by the Department for dates of service on or after July 1, 2012.
- B. Except for drugs which shall be billed to the Program using the National Drug Code (NDC) and the appropriate HCPCS, the Department shall reimburse the facility 80% of the Medicare clinic prospective rate which is based on a prospectively determined standard visit. The visit includes an overhead amount per procedure derived from an estimate of the cost. Under OPPOS, CMS pays for clinic services on a rate per visit that varies according to the ambulatory payment classification (APC). Medicaid will continue to pay provider based outpatient oncology facilities the full annual deductible as well as the full 20% Medicare Part B coinsurance amount for all APG Medicare/Medicaid crossover claims.
- C. The provider may not bill the program or the recipient for:
 - 1. Completion of forms or reports;
 - 2. Broken or missed appointment;
 - 3. Services which are provided at no charge to the general public; or
 - 4. Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient.
- D. The Program makes no direct payments to recipients.
- E. The billing time limitations are set forth in Preface to Attachment 4.19B

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Specific Payment Procedures for Urgent Care Centers

- A. Urgent care centers are reimbursed a \$50 facility fee, which is determined by the Program. This reimbursement methodology was set January 1st, 2014 and is effective for services provided on or after that date. The rate is the same for both governmental and private individual providers.
- B. In addition to the facility fee, the Program shall reimburse for services rendered by the physician during the visit at the free-standing urgent care center when performed by a physician, or by other authorized personnel under that physician's supervision. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo
- C. The provider may not bill the Program or the recipient for:
 - 1. Completion of forms or reports;
 - 2. Broken or missed appointments;
 - 3. Providing a copy or a recipient's medical record when requested by another licensed provider on behalf of the recipient.
- D. The Program makes no direct payments to recipients.
- E. The billing time limitations are set forth in the Preface to Attachment 4.19B.

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2a. OUTPATIENT HOSPITAL SERVICES

- 1) All hospitals located in Maryland which participate in the Program and are regulated by the All Payer Hospital Rate System, except those listed in 2 through 6 below, will charge-and payers will reimburse—according to rates approved by the HSCRC, pursuant to the HSCRC statute and regulation. Under this system, all regulated hospitals are required to submit to the HSCRC base year data using a uniform accounting and reporting system. The HSCRC established approved rates for units of service in the various revenue producing departments (rate centers). The rates include adjustments for such items as inflation, volume changes, pass-through costs, and uncompensated care. A description of the HSCRC's uncompensated care methodology is described in Attachment 4.19A Section 1. A. The HSCRC posts each hospital's rates by rate center on the HSCRC website:
http://www.hscrc.maryland.gov_Rates2.cfm
- 2) The Program will make no direct reimbursement to any Maryland State-operated chronic hospital, or psychiatric hospital.
- 3) An acute general or special hospital not located in Maryland or DC will be paid the host State Medicaid rate.
- 4) Beginning with fiscal year 2007, private freestanding pediatric rehabilitation hospitals in Maryland not approved for reimbursement according to the HSCRC rates, shall be reimbursed for outpatient expenditures using a prospective rate which is calculated based on the lower of cost from the Medicare 2552 Cost Report or up to 100% of outpatient charges. The percentage of charges reimbursed is adjusted annually by increasing the audited 2004 Medicare 2552 cost report trended forward times the Outpatient Prospective Payment System market basket update factor.
- 5) Psychiatric Hospitals Outpatient costs are reimbursed based on Medicare's retrospective cost reimbursement principles utilizing the Medicare cost report. The percentage of charges is calculated by taking outpatient charges divided by outpatient cost.
 - a. Medicare standards for retrospective cost reimbursement described in 42 CFR Part 413 as filed in the Medicare 2552 cost report; or
 - b. On the basis of charges if less than reasonable cost.

In calculating retrospective cost reimbursement rates, the Program or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, or groups of costs, or costs of specific groups of patients. When the cost, or group, or groups of costs, designated, cover services rendered to all patients, including MA recipients, operating costs applicable to all patients will be reduced by the amount of the restricted grants, gifts, or income from endowments thus resulting in a reduction of allowable costs.

6. D.C. Outpatient

A hospital located in D.C. for outpatient services shall be paid a percentage of charges based on the result of **multiplying** the Factors 1 and 2 then **adding** Factor 3 as follows:

- Factor 1 is the report period cost-to-charge ratio. This factor, which is determined by an analysis of the hospital's most recent Medicare 2552 cost report as filed by the Maryland Medical Assistance Program or its designee, establishes the cost-to-charge ratio for the hospital during the cost report period.
- Factor 2 is the cost-to-charge projection ratio. This factor, which is determined by an analysis of the hospital's three most recent cost reports performed by the Program or its designee, projects the cost-to-charge ratio from the cost report periods two years prior to the latest cost report to the prospective payment period. The annual rate of change is applied from the mid-point of the report period used to develop Factor 1 to the mid-point of the prospective payment period. To reflect the accelerating pace of cost-to-charge ratio decreases, Factor 2 shall not be greater than 1.000.
- Factor 3: Beginning July 1, 2011 rates calculated according to Factor 1 and 2 above will be adjusted upward by 2.0 percentage points.

2.b. RURAL HEALTH CLINIC SERVICES

RHCs and FQHC services are considered the same. Reimbursement is listed in Section 2.c. below

TN # 11-14-B

Supersedes TN # NEW

Approval Date

SEP 21 2012

Effective Date July 1, 2011

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2.c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Federally qualified health center (FQHC), Rural Health Centers (RHCs), and other ambulatory services furnished by these facilities are cost-based and facility-specific, except as provided in subparagraph (4)(d). Subparagraphs (1) through (3) and (4)(a) through (c) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

- 1) Effective for dates of service occurring January 1, 2001 and after, FQHCs/RHCs were reimbursed on a prospective payment system (PPS). The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the clinic's fiscal years 1999 and 2000. The base PPS is tied to the average current FQHC/RHC urban/rural rate in the year the rate was set and adjusted annually by the percentage increase in the Medicare Economic Index (MEI).
- 2) A change in scope of services is a change in the type, intensity, duration, and/or amount of services, not just the type of services delivered. The change in a cost of service in and of itself, is not considered a change in the scope of services. In the event that the provider elects to institute a scope of services change, the provider shall:
 - a) Notify the Department of its intent to institute the scope of services change no later than 30 days before it begins to deliver services under the scope of services change.
 - b) The FQHC/RHC shall notify the Department of the change of scope. The FQHC/RHC may request a rate revision based on the change of scope of services. The FQHC/RHC must submit a cost report and supporting documentation within 90 days after the end of the first one-year period immediately following the implementation of the scope of services change. The cost report should reflect the change in costs relating to the rate revision request due to the implementation of the change of scope of services.
- 3) Newly qualified FQHCs/RHCs established after January 1, 2001, will have their rates established in the following manner and subject to the Alternative Payment Methodology (APM):
 - a) Providers shall be divided into those located in urban areas and those located in rural areas. Baltimore City and the Maryland counties of Allegany, Anne Arundel, Baltimore, Carroll, Cecil, Charles, Harford, Howard, Montgomery, Prince George's, St. Mary's and Wicomico are urban areas. All other Maryland counties are rural areas. Providers located out-of-State shall be placed in the same reimbursement class as that of the nearest Maryland county.
 - b) For the first two fiscal years of operation, an interim all-inclusive cost-per-visit rate shall be established for primary care and for dental care services, if applicable, for each provider, by averaging the current FQHC all-inclusive cost-per-visit rate amounts for each area, urban or rural.
 - c) The Department or its designee shall request from the FQHC/RHC, cost reports for the first 2 fiscal years of operation.
 - d) The Department or its designee shall calculate a final rate that is an average of the first two fiscal years of operation. The final rate is equal to 100% of their average reasonable costs.
 - e) The Department will reconcile the interim rate to the final rate for the FQHC/RHC.

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- f) The final all-inclusive cost-per-visit rate shall be implemented retroactively to the start date of the FQHC's operation.
- 4) Alternative Payment Methodologies. All FQHCs must agree to receive the APM.
- a) As of January 1, 2005, the Department implemented an APM for a primary care and dental rate. As of January 1, 2010 all existing FQHCs/RHCs elected to be reimbursed with the APM.
- (i) The payment rate under the APM for covered FQHC/RHC services furnished to Medicaid beneficiaries is equal to 100 per cent of their average reasonable costs.
 - (ii) Reimbursement shall occur on a per-visit basis with one rate for primary care and another for dental. The primary care rate equals primary care costs divided by primary care visits. The dental rate equals dental care costs divided by dental care visits. For both services, providers will be grouped as urban or rural centers.
 - (iii) Allowable costs will be determined in accordance with Medicare principles of reasonable cost reimbursement as contained in 2 CFR 200.
 - (iv) Allowable costs relating to covered Maryland Medical Assistance services are included in the federally qualified health center's reimbursement methodology and will continue to be used in the calculation of the baseline APM rate.
 - (v) The rates are adjusted annually to reflect the increase or decrease in the Medicare Economic Index (MEI).
 - (vi) Rates paid under this cost-based reimbursement methodology must be at least equal to the payment under the payment methodology included in subparagraph (1).
 - (vii) The all-inclusive cost-per-visit rate for primary care visits covers the allowable costs associated with covered primary care, mental health, and substance abuse services. FQHCs may not charge the program, other than an all-inclusive cost-per-visit rate, for any ambulatory service. Primary care services costs are composed of those costs, including supplies, associated with health care staff, including laboratory technicians, who provide direct care to patients;
 - (viii) The all-inclusive cost-per-visit rate for dental care visits covers only those services that are reimbursed by the Program. Other dental services are not reimbursable. Dental services costs are the costs of supplies and health care staff associated with the provision of dental services to patients; and
- b) Under the APM, the FQHCs/RHCs are paid their full per-visit rate by the Managed Care Organization (MCO) when the service is rendered. The MCO shall receive an interim supplemental payment once every 3 months (quarterly). Each FQHC must agree to receive full payment through the MCO under this APM.
- c) Effective with dates of service December 18, 2020, the Department will pay only FQHCs and RHCs that agree to accept this APM and agree that the Medicaid rate covers their increased costs associated with COVID-19 vaccine only visits in supplement to their PPS rate. The Department will pay the Medicaid rate for the administration of COVID-19 vaccines administered during a COVID-19 vaccine-only visit by staff who have authority under state law to administer the vaccine and are covered under the Maryland Medicaid State Plan. The supplemental amounts made under this APM are in addition to the PPS paid to

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FQHCs/RHCs for an encounter. The amount in total paid to FQHC and RHC providers is at least their provider-specific PPS rate.

This APM was developed to support FQHCs/RHCs, as a key COVID-19 vaccine provider identified in the Maryland COVID-19 vaccination strategy. Payments under this APM are to cover the additional costs associated with the administration of the COVID-19 vaccines by FQHCs/RHCs during COVID-19 vaccine-only visits as the PPS cost base for FQHCs/RHCs did not include these costs. The supplemental amount paid under this APM is the Medicaid rate for the administration of COVID-19 vaccines, which is equivalent to the Medicare rate developed by CMS to account for the additional costs associated with the administration of COVID-19 vaccines. This rate is being used as FQHC/RHC cost data history is not available for rate development and is the same rate paid to other outpatient clinics that have comparable costs for the administration of COVID-19 vaccines. FQHCs/RHCs that opt-in to this APM must agree that the Medicaid rate covers their increased costs associated with COVID-19 vaccine only visits in supplement to the PPS rate.

FQHCs/RHCs will receive the Medicaid rate for each administration of a COVID-19 vaccine administered during a COVID-19 vaccine-only visit, effective for dates of service beginning December 18, 2020 and continuing through the last day the federal government coverage the vaccine's ingredient cost.

Effective August 1, 2022, when the federal government covers 100% of a vaccine's ingredient cost and where the Program has not established separate administration rate(s) for specific vaccines (e.g. monkeypox), the Program will provide reimbursement for vaccine administration for federally purchased vaccines to adults at the higher of:

- (1) The VFC administration rate; or
- (2) If applicable, 100% of the Medicare rate for the CMS-designated vaccine administration code for that vaccine.

The supplemental payments under this APM are only for COVID-19 or other federally purchased vaccine-only visits. If the federally purchased vaccine is administered as part of a billable encounter visit, then the FQHC/RHC will only receive their provider-specific PPS/APM rate. FQHCs/RHCs may not receive a supplemental payment under this APM and a PPS payment for encounters that include the administration of a federally purchased vaccine.

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28. Freestanding Birth Centers: Reimbursement

Licensed or Otherwise State-Approved Freestanding Birthing Centers

Freestanding birthing centers are reimbursed a facility fee. The birthing center facility fee is consistent across birthing centers. The reimbursement methodology was set on September 1st, 2014. Physicians and Certified Nurse Midwives providing services in the freestanding birthing centers are reimbursed as previously referenced in Attachment 4.19B in the State plan under Physician Services section and Certified Nurse Midwives Services section. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of birthing center services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Department's website using the link provided above.

A. Payment for Drugs shall be as follows:

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy shall be lower of:
 - a. The provider's usual and customary (U & C) charge to the public, as identified by the claim charge, or
 - b. The National Average Drug Acquisition Cost (NADAC) of the drug plus a Professional Dispensing Fee (PDF) of \$ 10.67 and when NADAC is unavailable:
 - i. The Wholesale Acquisition Cost (WAC) + 0% plus a PDF of \$ 10.67; or
 - ii. The Federal Upper Limit (FUL) plus a PDF of \$ 10.67; or
 - iii. The State Actual Acquisition Cost (SAAC) plus a PDF of \$ 10.67. SAAC is defined as the ingredient cost of any drug based upon a survey of providers' actual prices paid to acquire drug marketed or sold by specific manufacturers, when NADAC is unavailable.
2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail shall be lower of:
 - a. The provider's usual and customary (U & C) charge to the public, as identified by the claim charge, or
 - b. The National Average Drug Acquisition Cost (NADAC) of the drug plus a Professional Dispensing Fee (PDF) of \$ 10.67 and when NADAC is unavailable:
 - i. The Wholesale Acquisition Cost (WAC) + 0% plus a PDF of \$ 10.67; or
 - ii. The Federal Upper Limit (FUL) plus a PDF of \$ 10.67; or
 - iii. The State Actual Acquisition Cost (SAAC) plus a PDF of \$ 10.67.
3. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) shall be the lower of:
 - a. The provider's usual and customary (U & C) charge to the public, as identified by the claim charge, or
 - b. The National Average Drug Acquisition Cost (NADAC) of the drug plus a Professional Dispensing Fee (PDF) of \$ 11.67 and when NADAC is unavailable:
 - i. The Wholesale Acquisition Cost (WAC) + 0% plus a PDF of \$ 11.67; or
 - ii. The Federal Upper Limit (FUL) plus a PDF of \$ 11.67; or
 - iii. The State Actual Acquisition Cost (SAAC) plus a PDF of \$ 11.67.
4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence shall be the lower of:
 - a. The provider's usual and customary (U & C) charge to the public, as identified by the claim charge, or

- b. Wholesale Acquisition Cost (WAC) + 0% plus a Professional Dispensing Fee (PDF) of \$10.49, or
 - c. The Actual Acquisition cost (AAC) + 8% plus a PDF of \$10.49. AAC is defined as the invoice submitted by the provider to the Program for a clotting factor.
- 2. 3408 covered entities and Federally Qualified Health Centers (FQHCs) that fill Medicaid member prescriptions with drugs purchased at the prices authorized under Section 3408 of the Public Health Services Act will be reimbursed no more than the actual acquisition cost for the drug plus a \$12.12 Professional Dispensing Fee. 3408 covered entities that fill Medicaid member prescriptions with drugs not purchased under the Section 3408 of the Public Health Services Act will be reimbursed in accordance to section (A) (1)-(4).
 - 3. Drugs purchased through the Federal Supply Schedule (FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.49 Professional Dispensing Fee.
 - 4. Drugs purchased at Nominal Price (outside of 3408 or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.49 Professional Dispensing Fee.
 - 5. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at the provider's acquisition cost. PADs purchased at the prices authorized under Section 340B of the Public Health Services Act and submitted by FQHCs under the medical benefit will be part of all-inclusive payment rate.
 - 6. Investigational drugs are not a covered service under the Maryland Medicaid.
 - 7. Select prescribed drugs that do not meet the definition of covered outpatient drugs will be reimbursed at the same rate as covered outpatient drugs.

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Durable Medical Equipment (DME), Disposable Medical Supplies (DMS), Prosthetics, and Orthotics

A unit of service is an item and quantity as prescribed by the physician. Quantities above the pre-established limits require prior authorization to establish medical necessity. Medical equipment services, prosthetics and orthotics reimbursed above \$1000, and medical supply services reimbursed above \$500, require prepayment authorization.

The Department will reimburse for covered prosthetic devices annually, on a rolling 12-month interval, when deemed medically necessary by a Medicaid-enrolled provider for use in enrollee's home, school or place of employment, or for the purpose of performing physical activities including running, biking, swimming, strength training and other activities to maximize overall health including improving lower and upper limb function.

The DME/DMS Program does not cover:

- (1) Disposable medical supplies usually included with the office visit;
- (2) Completion of forms and reports; and
- (3) Fitting, dispensing, or follow-up care.

The rates and processes below apply to all Medicaid enrolled providers. The current fee schedule is published on the Department's website at:

<https://health.maryland.gov/mmcp/communitysupport/Pages/Home.aspx> under Medicaid DME/DMS/Oxygen Approved List of items.

Purchased Medicare-Covered DME and DMS:

For Medicare-covered DME, DMS, prosthetics, and orthotics, the State of Maryland reimbursement rate is set at 85% of the lowest rural, non-rural, or competitive bidding area (CBA) Medicare rate established for Maryland as set on January 1st of each calendar year; that rate will remain in effect the entire calendar year.

Rental Reimbursement for Medicare-Covered DME:

Monthly rental reimbursement for Medicare-Covered DME, is 85% of the lowest rural, non-rural, or competitive bidding area (CBA) Medicare purchase price established for Maryland as set on January 1st of each year, divided over ten months. The monthly rental rate will remain in effect the entire calendar year. The formula for the monthly rental rate is as follows

$$\text{Medicaid Monthly Rental Rate} = 85\% \text{ of Medicare Purchase Price} \div 10$$

For items that can be rented prior to purchase, the item is considered purchased after ten months of rental payments.

Purchase Reimbursement for DME and DMS for which there is no Medicare Rate:

For items for which Medicare has not established a rate whether or not the item is covered by Medicare:

- (1) DME at the provider's choice of the manufacturer's suggested retail price (MSRP) minus 41.2% or the provider's wholesale cost plus 27.4%;
- (2) Incontinence supplies at the provider's wholesale cost plus 25%;
- (3) All other DMS at the provider's choice of the MSRP minus 41.2% or the provider's wholesale cost plus 37.2%; and
- (4) Customized equipment at the provider's choice of the MSRP minus 30% or the provider's wholesale cost plus 40%.

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Rental Reimbursement for DME for which there is no Medicare rate:

For rental items for which Medicare has not established a purchase rate, items will be rented at the provider's choice of:

- (1) The manufacturer's suggested retail price minus 41.2 percent, divided over ten months; or
- (2) The provider's wholesale cost plus 27.4 percent, divided over ten months.

For items that can be rented prior to purchase, the item is considered purchased after ten months of rental payments.

Repairs

The Department shall reimburse for covered repairs to purchased durable medical equipment according to the following methodology:

- (1) The provider's choice of wholesale cost plus 37.2 percent or the manufacturer's suggested retail price minus 31.4 percent to the provider for all materials;
- (2) Labor costs shall be billed in quarter hour increments using the appropriate procedure code and shall be reimbursed the lesser of:
 - (a) The supplier's customary charge unless the service is free to individual not covered by Medicaid; or
 - (b) The reimbursement rate specified in the Medicaid Durable Medical Equipment Program's approved list of items.

Repair of Prosthetic Devices and Components of Prosthetic Devices

- (1) The Department will reimburse for covered repair for prosthetic devices and components of prosthetic devices annually, on a rolling 12-month interval when deemed medically necessary by a Medicaid-enrolled provider and when the repair's necessity is not due to misuse.
- (2) Repairs are covered annually, on a rolling 12-month interval when deemed medically necessary by a Medicaid-enrolled provider for use in enrollee's home, school or place of employment, or for the purpose of performing physical activities including running, biking and swimming, strength training and other activities to maximize overall health.
- (3) The Department will reimburse for covered repairs of prosthetic devices and components of prosthetic devices only when adequate documentation is obtained by the ordering provider.

Limitation on Repairs

- (1) The Department will not reimburse for repairs of prosthetic devices and components of prosthetic devices in the event that an ordering health care provider determines that the prosthetic devices and components of prosthetic devices are damaged as a result of misuse.
- (2) In the event that the repair costs are 60% higher than replacement costs, the ordering health care provider will replace the affected prosthetic device and components of prosthetic device according to the requirements and limitations related to replacements.

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Replacement of Prosthetic Devices and Components of Prosthetic Devices

- (1) Replacement of prosthetic devices are covered annually, on a rolling 12-month interval for devices less than three years old if the replacement is required for the following reasons:
 - a) A change in the physiological condition of the participant;
 - b) Unless necessitated by misuse, because of an irreparable change in the condition of the prosthetic device or the component of the prosthetic device; or
 - c) Unless necessitated by misuse, because the condition of the prosthetic device or the component of the prosthetic device requires repairs and the cost of the repairs would be more than 60% of the cost of replacing the prosthetic device or the component of the prosthetic device.
- (2) Replacements will be made annually, on a rolling 12-month interval when deemed medically necessary by a Medicaid-enrolled provider for use in enrollee's home, school or place of employment, or for the purpose of performing physical activities including running, biking and swimming, strength training and other activities to maximize overall health.

Limitations on Replacement

- (1) The Department may require an ordering health care provider to confirm that the prosthesis and /or the component of the prosthesis, being replaced, meets the requirements for replacement and is less than three years old.

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Hearing Aids

The Department covers medically necessary hearing aids when the services are provided by appropriately licensed providers as described in the State Plan.

The Department's fee schedule was set as of July 1st, 2018, and is effective for services provided on or after that date. Except as otherwise noted in the State Plan, fee schedules are the same for both governmental and private individual practitioners. Any annual/periodic adjustments to the fee schedule are published on the agency's website.

1. Go to health.maryland.gov/providerinfo.
2. Navigate to the "Audiology Services information" header.
3. Select "Audiology, Physical Therapy, and Early Periodic, Screening, Diagnosis and Treatment (EPSDT) Provider Manual" to view the fee schedule.

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Attachment 3.1A Item 12D: Eyeglasses

The reimbursement methodology was set July 1st, 2011 is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

- (1) Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients 21 years old and older;
- (2) Repairs, except when repairs to eyeglasses are more cost-effective than replacing with new eyeglasses; or
- (3) Routine adjustments.

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DME/DMS

Enteral Nutrition Products

Enteral nutritional products are covered when administered in the home and given by nasogastric, jejunostomy, or gastrostomy tube. Services require a post payment review.

Effective February 1, 2021, the Department will reimburse for enteral nutritional products at the below rates. These rates are the same for both governmental and private individual practitioners.

Enteral nutritional product reimbursement is based on Medicare rates where available. The following HCPCS are reimbursed per unit:

HCPCS	HCPCS Unit	Per Unit Rate
B4102	500 ml	\$3.56
B4103	500 ml	\$3.33
B4149	100 cal	\$1.77
B4150	100 cal	\$0.69
B4152	100 cal	\$0.57
B4153	100 cal	\$2.03
B4154	100 cal	\$1.20

HCPCS	HCPCS Unit	Per Unit Rate
B4155	100 cal	\$1.19
B4158	100 cal	\$0.69
B4159	100 cal	\$0.69
B4160	100 cal	\$0.85
B4161	100 cal	\$2.03
B4162	100 cal	\$3.31

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DME/DMS

Enteral and Parenteral Therapy Supplies

Effective February 1, 2021, the Department will reimburse for enteral and parenteral supplies (B codes) at 85 percent of the July 2013 Medicare rates. These rates are the same for both governmental and private individual practitioners.

The following HCPCS are reimbursed:

HCPCS	HCPCS Unit	Per Unit Rate
B4034	1 item	\$5.19
B4035	1 item	\$9.90
B4036	1 item	\$6.80
B4081	1 item	\$18.37
B4082	1 item	\$13.66
B4083	1 item	\$2.10
B4087	1 item	\$30.32
B4088	1 item	\$107.11

HCPCS	HCPCS Unit	Per Unit Rate
B4220	1 item	\$7.65
B4222	1 item	\$9.44
B4224	1 item	\$22.69
B9002	1 item	\$1,041.91
B9004	1 item	\$2,411.31
B9006	1 item	\$2,411.31
B9998	1 item	\$249.90
B9999	1 item	\$249.90

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3. Other Lab and X-ray Services: Laboratory Services

In accordance with CFR §440.30, laboratory services means a professional and technical laboratory service.

The reimbursement methodology was set on July 1st, 2012 and is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

- (1) Services for which the medical laboratory provider cannot supply a properly completed order or standing order identifying the authorized ordering practitioner;
- (2) Services not adequately documented in the recipient's medical records;
- (3) Services denied by Medicare as not medically necessary;
- (4) Clinical laboratory services, for which certification by CMS under CLIA is required, when these services are performed by laboratories that are not certified to perform those services;
- (5) Procedures that are investigational or experimental in nature;
- (6) Services included by the Program as part of the charge made by an inpatient facility, hospital outpatient department, freestanding clinic, or other Program-recognized entity;
- (7) Medical laboratory services related to autopsies; or
- (8) Medical laboratory services for which there was insufficient quantity of specimen, improper specimen handling, or other circumstances that would render the results unreliable.

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3. Other Lab and X-ray Services: X-ray Services

In accordance with CFR §440.30, x-ray services means a professional and technical radiological service.

The reimbursement methodology was set on July 1st, 2012 and is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

- (1) Services not medically necessary;
- (2) Investigational and experimental drugs and procedures;
- (3) Services denied by Medicare as not medically necessary; or
- (4) Services which do not involve direct patient contact (face-to-face).

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Local Health Departments and General Clinics

The reimbursement methodology was set January 1st, 2012 and is effective for Local Health Departments.

A unit of service is a visit or procedure as defined in the American Medical Association Current Procedural Terminology (AMA CPT). In addition, the State will pay the federally calculated VFC vaccine administration charge. Rates are the same for both governmental and private individual practitioners and are reimbursed based on the current fee schedule published on the Department's website at:

health.maryland.gov/providerinfo

Dentists are reimbursed according to the dental fee schedule referenced on Att. 4.19B page 13.

The Department does not pay for:

- (1) Any services identified by the Department as not medically necessary or not covered;
- (2) Investigational and experimental drugs and procedures;
- (3) Visits solely for the purpose of one or more of the following:
 - a. Prescription, drug or supply pick-up, or collection of laboratory specimens;
 - b. Ascertaining the patient's weight; or
 - c. Measurement of blood pressure.
- (4) Injections and visits solely for the administration of injections;
- (5) Immunizations required for travel outside the Continental U.S.;
- (6) Visits solely for group or individual health education
- (7) Separate billing for services which are included as part of another service; or
- (8) Separate reimbursement to a physician for services provided in a clinic in addition to the clinic reimbursement.

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Free-standing Dialysis Facility Services

The Department's rate for Free-standing dialysis facilities is 62.5% of Medicare's bundled rate for dialysis. In addition to paying approximately 62.5% of the bundled Medicare rate, the Department reimburses the dialysis facility separately for:

- 1) Laboratory Services;
- 2) Supplies; and
- 3) Drugs.

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State of Maryland

Family Planning Clinics

The state-developed reimbursement methodology was set January 1st, 2012 and is the same for both governmental and private individual practitioners. A unit of service is a visit or procedure as defined in the American Medical Association Current Procedural Terminology (AMA CPT). For dates of service between January 1, 2013 and December 30, 2014, provider rates for Evaluation and Management (E&M) procedure codes were set at 100 percent of Medicare mean. In addition the State will pay the federally calculated VFC vaccine administration charge. Physicians are reimbursed based on the current fee schedule available on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

- (1) Any services identified by the Department as not medically necessary or not covered;
- (2) Investigational and experimental drugs and procedures;
- (3) Visits solely for the purpose of one or more of the following;
 - a. Prescription, drug or supply pick-up, or collection of laboratory specimens;
 - b. Ascertaining the patient's weight; and
 - c. Measurement of blood pressure;
- (4) Injections and visits solely for the administration of injections;
- (5) Immunizations required for travel outside of the Continental U.S.;
- (6) Separate billing for services which are included as part of another service; or
- (7) Separate reimbursement to a physician for services provided in a clinic in addition to the clinic reimbursement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Outpatient Mental Health Clinics

- The Department reimburses Outpatient Mental Health Centers (OMHCs) for outpatient therapeutic treatment services on a per session basis. Sessions are delivered in units of time ranging from 20 minutes to 80 minutes. OMHCs may also be reimbursed for psychological testing and interpretation of test results. OMHC staff must include staff from two different licensed mental health professional classes, which includes: psychiatrists licensed doctoral psychologists, nurse psychotherapists, licensed and certified social workers, licensed and certified professional counselors, and certified nurse practitioners. Services and provider qualifications are limited to those outlined in Attachment 3.1A page 22 of the Maryland State Plan.
- Limitations:
 - All services must be preauthorized by the Department or its designee;
 - The Department does not reimburse for outpatient mental health services provided to an individual when the individual is in a hospital, institution for mental disease (IMD), or residential treatment center;
 - The Department does not reimburse a psychologist for more than eight (8) hours of psychological testing per patient per year;
 - The Department does not reimburse services provided by a school health-related service provider that are not included on a child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP);
 - The Department does not reimburse for services which do not involve direct, face-to-face, patient contact; and
 - The Department does not cover investigational and experimental drugs, procedures, or therapies.
- Both government and non-government practitioners are reimbursed pursuant to the same fee schedule. OMHCs are paid by CPT code or HCPCS codes which are based on Medicare reimbursement. The Department's methodology rates for OMHC providers are in effect as of January 1, 2012.
- State-developed fee schedule rates are the same for both governmental and private. Updated rates are included on the current fee schedule which is published on the Department's website at:

health.maryland.gov/providerinfo

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Licensed School Psychologists

- a. The Department reimburses for licensed school psychologists. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan.
- b. The Department reimburses schools for mental health services within the provider's scope of practice when required under an Individual Education Program (IEP) or Individual Family Service Plan (IFSP) and when provided by a licensed school psychologist. These services include: individual psychotherapy, family psychotherapy, group psychotherapy, and psychological testing. The State will reimburse for this service at the same rate that it reimburses all other non-governmental mental health providers as described in 18b.
- c. Effective January 1, 2025, the Department reimburses schools for mental health services within the provider's scope of practice for recipients who do not have an IEP or IFSP and when provided by an MSDE licensed school psychologist.
- d. The State will reimburse for services described in b and c at the same rate that it reimburses all other non-governmental mental health providers as described in 18b.
- e. Limitations:
 - 1) The Department reimburses only for one service per service date; and
 - 2) The Department does not reimburse for school-based mental health services provided to an individual when the individual is in a hospital or residential treatment center; and
 - 3) The Department does not reimburse mental health services provided by a school health-related services provider that are not included on a child's IEP or IFSP for dates of service prior to January 1, 2025.

Preauthorization: The Department may provide an exception to the first limitation rule above if it, or its agent, finds the additional service is medically necessary, not duplicative.

- f. Payment limitations:
 - The Department will not pay for services which do not involve direct, face-to-face patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail;
 - Services which are provided at no charge to the general public with the exception of certain mental health services that are rendered in the school setting to eligible recipients; and
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Prosthetic Devices

A unit of service is an item and quantity as prescribed by the physician.

The Department does not pay for:

- (1) Items which are investigational or experimental in nature; or
- (2) Completion of forms and reports.

The state-developed reimbursement methodology is effective July 1st, 2012 and is the same for both governmental and private practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

STATE OF MARYLAND

23. A. Transportation Services are reimbursed according to the following:

1. Emergency Service Transporters:

Pay enrolled providers for transporting Medicaid recipients to appropriate facilities in response to an emergency "911" call. The fee for this service is established in the enabling legislation. The current rate is set to \$150 and is updated only through legislation. Emergency transportation service providers and limitations are defined per Attachment 3.1A, page 30 and shall be paid based on a fee-for service schedule.

The agency's fee schedule rate was set as of July 1, 2022 and is effective for services provided on or after that date. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners.

2. Transportation under the Individuals with Disabilities Education Act (IDEA):

These transportation services are provided as an optional service for only those individuals who qualify for and require it as part of their Individualized Education Program or Individualized Family Service Plan. IDEA transportation service providers and limitations are defined per Attachment 3.1-A, page 30-A.

Costs included in the statewide calculation are: Bus Driver Salaries and Benefits, Substitute Drivers Salaries and Benefits, Fuel, Repairs & Maintenance, Contractors payments, training, and Other Operating Expenses. School systems do not calculate depreciation and attendants are not in the transportation budget.

The agency's fee schedule rate was set as of January 1, 2004 and is effective for services provided on or after that date. All rates are published on the agency's website at health.maryland.gov/providerinfo under the "EPDST/Healthy Kids Resources" header. Any annual/periodic adjustments to the fee schedule are published in the website above.

Maryland defines 1 unit as transportation in one direction. For example, home to school or school to home. Transportation provided to and from school bills as 2 units.

NEMT services are located in Attachment 3.1 D

3. Emergency Service Transporter Supplemental Payment Program (ESPP).

- (a) Reimbursement rates for Emergency Service Transporters are outlined in Attachment 4.19-B, page 40.

(b) SUPPLEMENTAL PAYMENT FOR JURISDICTIONAL EMERGENCY MEDICAL SERVICES OPERATIONAL PROGRAMS

Effective October 1, 2020, Jurisdictional Emergency Medical Services Operational Programs (JEMSOPs) that meet the specified requirements outlined in Section 3(c) below and provide ground emergency transportation services to Medicaid recipients as defined in Attachment 3.1A page 30, will be eligible for a supplemental payment. This supplemental payment applies to Emergency Transportation Services (ETS) rendered to Medicaid recipients by eligible JEMSOPs on or after October 1, 2020. EPSS is a voluntary program, and JEMSOPs are not required to participate.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to Emergency Service Transporters in accordance with Attachment 4.19-B, page 40 that eligible entities receive for ETS services rendered to eligible Medicaid recipients. Total reimbursements under the ESPP program are capped (including supplemental payments) at one hundred percent of actual costs. The Maryland Department of Health (the Department) will recognize a supplemental payment equal to the total allowable Medicaid costs of eligible JEMSOPs for providing services as set forth below.

- (c) To qualify for supplemental payments, providers must meet all of the following:

1. Be enrolled as a Medicaid provider for the period being claimed on their annual cost report;
2. Provide ground Emergency Transport Services to Medicaid recipients; and
3. Be a "Jurisdictional Emergency Medical Services Operational Program," which is defined under COMAR 30.03.02 as: "an institution, agency, corporation, or other entity that has been approved by the Emergency Medical Service Board to provide oversight for each of the local government and State and federal emergency medical services programs."

Providers meeting all of these qualifications will be considered "Eligible Providers."

- (d) Supplemental Reimbursement Methodology – General Provisions

TN No. 20-0010
Supersedes TN No. NEW

Approval Date 3/16/21
Effective Date October 1, 2020

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning those expenses to the Medicaid program, except as expressly modified below.
2. The total uncompensated care costs of each Eligible Provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each Eligible Provider providing ETS to Maryland Medicaid recipients, net of the amounts received and payable from the Maryland Medicaid program and all other sources of reimbursement for such services provided to Maryland Medicaid recipients. If the Eligible Providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

(e) Cost Determination Protocols

1. An Eligible Provider's specific allowable cost per-ETS transport rate will be calculated based on the provider's financial data reported on the state-approved cost report. The per-ETS transport cost rate will be the sum of actual allowable direct and indirect costs of providing ETS divided by the actual number of emergency transports provided for the applicable service period.
2. Direct costs for providing ETS include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services ETS, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the ETS.
3. The total percentage of time spent on ETS calls throughout the cost reporting period will be calculated using Computer Aided Dispatch (CAD)/trip allocation statistics and used as an allocation methodology for those costs "shared" between ETS vs. Non-ETS

divisions. Eligible Providers will allocate shared Capital Related and Salaries & Benefits (CRSB) costs based on CAD/trip allocation statistics.

4. Indirect costs are determined in accordance to one of the following options.
 - a. Eligible Providers receiving more than \$35 million in direct federal funding in a calendar year must either have a Cost Allocation Plan (CAP) or a cognizant department approved indirect rate agreement in place with its federal cognizant department to identify indirect cost. If the Eligible Provider does not have a CAP or an indirect rate agreement in place with its federal cognizant department and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.
 - b. Eligible Providers receiving less than \$35 million of direct federal funding in a calendar year are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, Eligible Providers may use methods originating from a CAP to identify its indirect cost. If the Eligible Provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.
 - c. Eligible Providers receiving no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
 - i. A CAP with its local/municipal government
 - ii. An indirect rate negotiated with its local government
 - iii. Direct identification through use of a cost report
 - d. If the Eligible Provider never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost.

(f) Cost Settlement Process

1. The payments and the number of ETS transports reported in the as-filed cost report will be reconciled with the Department's Medicaid Management Information System (MMIS) reports generated for the cost reporting period within 12 months of the as-filed cost report deadline. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

2. Each Eligible Provider will receive an annual lump sum payment in an amount equal to the total of the uncompensated care costs as defined in the above Supplemental Reimbursement Methodology – General Provisions Section 3(d)(2).
3. The Department will perform a final reconciliation where it will settle the Eligible Provider's annual cost report as reviewed and/or audited within the following calendar year. The Department will compute the net ETS allowable costs using reviewed and/or audited per-ETS cost, and the number of fee-for-service ETS transports reflected in the updated MMIS reports. Actual net allowable costs will be compared to the total Medicaid reimbursement paid to the provider for eligible services, including claims payments, third party liability, copayments, spenddown, settlement payments made, and any other source of reimbursement received by the Eligible Provider for the period. If, at the end of the final reconciliation, it is determined that the Eligible Provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the Eligible Provider will receive a final supplemental payment in the amount of the underpayment.

(g) Eligible Provider Reporting Requirements

1. Cost reports are due no later than 180 days after the last day of the State Fiscal Year. A request for an extension shall only be approved when a provider's operations are significantly and/or adversely affected due to extraordinary circumstances, which the provider has no control, such as, flood or fire. The written request must include a detailed explanation of the circumstances supporting the need for additional time and be postmarked within the 180 days after the last day of the applicable State Fiscal Year. Filing extensions may be granted by the Department for good cause, but such extensions are made at the discretion of the Department.
2. Only cost reports from Eligible Providers as defined in Section 3(c) will be accepted.
3. Participating Eligible Providers who meet the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with 3(c) through 3(f) for services provided on or after October 1, 2020.
 - a. Eligible Providers will be paid interim rates equal to the Medicaid reimbursement rates paid to other ETS providers in accordance with Attachment 4.19-B, page 40. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate

transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.

- b. Eligible Providers will submit a state approved cost report annually, on a form approved by the Department.
- c. "Allowable costs" will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 CFR, part 200 as implemented by HHS at 45 CFR, part 75.
 - i. "Direct costs" are those costs that are identified by 45 CFR 75.413 that:
 - 1. Can be identified specifically with a particular final cost objective (to meet emergency transportation service requirements), such as a federal award, or other internally or externally funded activity; or
 - 2. Can be directly assigned to such activities relatively easily with a high degree of accuracy.
 - ii. "Indirect costs" means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.
- d. Eligible Provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio, to Medicaid transports associated with paid claims for the dates of service covered by the submitted cost report.

Reimbursement Methodology: Hospice Care

1. The Program will pay a hospice care provider at one of six rates for each day that a participant is under the provider's care. The daily payment rates for a provider for routine home care- first 60 days, routine home care-day 61 forward, service intensity add-on-last seven days of life, continuous home care, general inpatient care, and inpatient respite care will be in accordance with the Medicaid payment rates and the Medicare Wage Index established by the Centers Medicare and Medicaid Services (CMS) of the U.S Department of Health and Human Services for hospice care under a Medical Assistance Program. The rates and wage index are effective for services provided on or after the CMS publication date. Except as otherwise noted in the plan, state developed feeschedules and rates are the same for both governmental and private providers. A link to the published fee schedule can be found by going to the "Billing Guidance, Fee Schedules, and Preauthorization Information" section of the Maryland Medicaid Provider Information page at health.maryland.gov/providerinfo, and selecting the Professional Services Fee Schedule for the most recent year.

2. The six daily rates are prospective rates, and there will be no retroactive adjustment other than a limitation on payments for inpatient care.

- a. During the 12-month cap period beginning October 1 of each year and ending September 30 of the following year, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care the provider furnished to Medical Assistance hospice participants during the same period.
- b. If the aggregate number of inpatient care days exceeds the maximum allowable number, the limitation on reimbursement for inpatient care will be determined in accordance with the methodology established by CMS, and any excess reimbursement will be refunded to the Program by the provider.
- c. Any days of care furnished to participants diagnosed with Acquired Immune Deficiency Syndrome (AIDS) will be excluded in calculating the limitation on payment for inpatient care.

3. In addition to the daily rates for hospice care, the Program will make separate payment to the hospice care provider for physician services subject to the following requirements:

- a. The services must be direct patient care services furnished to a participant under the care of the provider;

- (b) The services must be furnished by an employee of the provider or under arrangements made by the provider;
 - (c) The provider must have a liability to reimburse the physician for the services rendered;
 - (d) No payment shall be made for physician services furnished on a volunteer basis; and
 - (e) Payment to the provider for physician services shall be made in accordance with the usual Program reimbursement policy and Maryland State fee schedule for physician services.
4. When a participant resides in a nursing facility, the Program will pay an additional per diem amount for room and board to the hospice care provider on those days that the provider is reimbursed at the routine home care rate or continuous home care rate for hospice care furnished to the participant.
- a. The amount will be 95% of the allowed nursing facility charges;
 - b. The amount will be paid only when the provider and the facility have a written agreement under which the provider is responsible for the professional management of the participant's hospice care and the nursing facility agrees to provide room and board to the participant.
5. For participants residing in a nursing facility, the Department of Human Resources shall determine the application of a recipient's resource to the cost of hospice care.
6. Requests for payment for hospice care rendered will be submitted according to procedures established by the Department. Payment requests which are not properly prepared or submitted may not be processed, but returned unpaid to the provider.
7. Requests for payment will be submitted on the invoice form specified by the Department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

**Reimbursement Methodology for Targeted Case Management Services –
On DDA Waiting List**

1. Effective July 2, 2020, payments for Targeted Case Management services to the Community as defined per Section 3.1A, Supplement 7 shall be paid based on a fee-for-service schedule. The rate is the same for both governmental and private individual practitioners.
2. Initial Eligibility and Access Comprehensive Assessment is reimbursed at a flat rate of \$450.
3. Effective July 1, 2022, the rate will be \$24.56 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
4. Effective July 1, 2022, a geographical differential rate of \$25.86 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
 - Calvert County;
 - Charles County;
 - Frederick County;
 - Montgomery County; and
 - Prince George's County.
5. For dates of service beginning October 1, 2022, a one-time temporary emergency rate increase of 10 percent using 100 percent American Rescue Plan Act (ARPA) funds will be applied. This temporary rate increase will expire on December 31, 2022.
 - a. The general rate will be \$27.02 per unit;
 - b. The geographic differential rate will be \$28.45 per unit; and
 - c. On January 1, 2023, the rates will revert back to the rates approved on July 1, 2022
6. Effective July 1, 2023, the rate will be \$25.54 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
7. Effective July 1, 2023, a geographical differential rate of \$26.89 per unit will apply for services rendered to individuals who live in specific Maryland counties. The

geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:

- Calvert County;
- Charles County;
- Frederick County;
- Montgomery County; and
- Prince George's County.

8. Effective January 1, 2024, the rate will be \$27.50 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
9. Effective January 1, 2024, a geographical differential rate of \$28.96 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
 - Calvert County;
 - Charles County;
 - Frederick County;
 - Montgomery County; and
 - Prince George's County
10. The State assures that billed time does not exceed available productive time by practitioner.
11. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1A, Supplement 7, §F. DDA Case Management Staff Qualifications.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

**Reimbursement Methodology for Targeted Case Management Services –
Transitioning to the Community**

1. Effective July 2, 2020, payments for Targeted Case Management services to the Community as defined per Section 3.1A, Supplement 7 shall be paid based on a fee-for-service schedule. The rate is the same for both governmental and private individual practitioners.
2. Initial Eligibility and Access Comprehensive Assessment is reimbursed at a flat rate of \$450.
3. Effective July 1, 2022, the rate will be \$24.56 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
4. Effective July 1, 2022, a geographical differential rate of \$25.86 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
 - Calvert County;
 - Charles County;
 - Frederick County;
 - Montgomery County; and
 - Prince George's County.
5. For dates of service beginning October 1, 2022, a one-time temporary emergency rate increase of 10 percent using 100 percent American Rescue Plan Act (ARPA) funds will be applied. This temporary rate increase will expire on December 31, 2022.
 - a. The general rate will be \$27.02 per unit;
 - b. The geographic differential rate will be \$28.45 per unit; and
 - c. On January 1, 2023, the rates will revert back to the rates approved on July 1, 2022
6. Effective July 1, 2023, the rate will be \$25.54 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
7. Effective July 1, 2023, a geographical differential rate of \$26.89 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the

State where the cost of living is higher due to other cost pressures or economic factors including:

- Calvert County;
- Charles County;
- Frederick County;
- Montgomery County; and
- Prince George's County.

8. Effective January 1, 2024, the rate will be \$27.50 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
9. Effective January 1, 2024, a geographical differential rate of \$28.96 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
 - Calvert County;
 - Charles County;
 - Frederick County;
 - Montgomery County; and
 - Prince George's County
10. The State assures that billed time does not exceed available productive time by practitioner.
11. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1A, Supplement 7, §F. DDA Case Management Staff Qualifications.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

**Reimbursement Methodology for Targeted Case Management Services –
Community Coordination Services**

1. Effective July 2, 2020, payments for Targeted Case Management services to the Community as defined per Section 3.1A, Supplement 7 shall be paid based on a fee-for-service schedule. The rate is the same for both governmental and private individual practitioners.
2. Initial Eligibility and Access Comprehensive Assessment is reimbursed at a flat rate of \$450.
3. Effective July 1, 2022, the rate will be \$24.56 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
4. Effective July 1, 2022, a geographical differential rate of \$25.86 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
 - Calvert County;
 - Charles County;
 - Frederick County;
 - Montgomery County; and
 - Prince George's County.
5. For dates of service beginning October 1, 2022, a one-time temporary emergency rate increase of 10 percent using 100 percent American Rescue Plan Act (ARPA) funds will be applied. This temporary rate increase will expire on December 31, 2022.
 - a. The general rate will be \$27.02 per unit;
 - b. The geographic differential rate will be \$28.45 per unit; and
 - c. On January 1, 2023, the rates will revert back to the rates approved on July 1, 2022
6. Effective July 1, 2023, the rate will be \$25.54 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
7. Effective July 1, 2023, a geographical differential rate of \$26.89 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the

cost of living is higher due to other cost pressures or economic factors including:

- Calvert County;
 - Charles County;
 - Frederick County;
 - Montgomery County; and
 - Prince George's County.
8. Effective January 1, 2024, the rate will be \$27.50 per unit to reflect a planned rate increase. A unit of service means a 15-minute increment.
9. Effective January 1, 2024, a geographical differential rate of \$28.96 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
- Calvert County;
 - Charles County;
 - Frederick County;
 - Montgomery County; and
 - Prince George's County
10. The State assures that billed time does not exceed available productive time by practitioner.
11. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1A, Supplement 7, §F. DDA Case Management Staff Qualifications.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Reimbursement for Targeted Case Management Services for Eligible Juveniles

1. Effective October 23, 2025 the Department will reimburse for Targeted Case Management Services for eligible juveniles at a rate of \$561.05 per unit. Services and Provider qualifications are limited to those outlined in Section 3.1M, Supplement 1.
2. Eligible juveniles are as defined in §1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within thirty days of their scheduled date of release from a public institution following adjudication, and for 30 days following release.
3. A unit of service shall mean a thirty day period of service, for a minimum of three case management contacts within that period which may be provided telephonically, in person, or via audio-visual telehealth.
4. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1M, Supplement 1. The targeted case management services shall be performed by a government agency responsible for housing and providing health care for eligible juveniles (e.g. the Department of Juvenile Services, or the Department of Public Safety and Correctional Services) during the pre-release period and either a government agency or a Medicaid MCO during the post release period. .
5. The State assures that payment will not be made for services provided to an inmate of a public institution, except when the individual is a patient in a medical institution or in the case of an eligible juvenile described in section 1902(a)(84)(D) with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section, as specified in paragraph (A) following the last numbered paragraph of section 1905(a) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

**1915(b)(4) Waivers Maryland Community First Choice 4.19B 1915 - K
Community First Choice State Plan Option Reimbursement**

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers of services provided under the Community First Choice Option. The Department's methodology was set on April 1st, 2017. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The following 1915(k) provider types are reimbursed in the manner described:

- I. State Plan Services
 - A. Personal Assistance Services: Rates are established using several factors. Preexisting rates across programs, collective bargaining with the Union, and the State's budget are all considered. Payment is based upon the total yearly budget established for personal assistance services for each participant as outlined per attachment 3.1 - K, page 3. Participants choosing to self-direct will be able to set rates for personal assistance providers. Personal assistance providers for participants in the agency model are required to use the Department's Electronic Visit Verification (EVV) system. Personal assistance providers for participants in the self-directed model are required to use the EVV system of the Financial Management and Counseling Services contractor selected by the participant. Effective July 1, 2023, personal assistance providers residing with participants to whom they are providing services may be exempted from the EVV requirement in accordance with Code of Maryland Regulations 10.09.36.03B(2)(c)(ii)-(d). Billing occurs based on an electronic claim generated by the call-in system in 15-minute increments. For individuals approved for up to 12 hours of personal assistance per day, payment will be made in 15-minute units of service. For individuals who are determined to need more than 12 hours of personal assistance per day, a daily rate for the service will be paid. All rates and rate ranges are defined in the above fee schedule.
 - B. Nurse Monitoring: The rate was developed based on preexisting rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at <http://dbm.maryland.gov>. As local health departments are sole providers of this service, in accordance with a 1915(b) waiver, one rate has been published for this service. Frequency for this service is established using criteria from the Maryland Nurse Practice Act. Billing occurs in 15-minute increments for this service.
 - C. Consumer Training: The rate was based on existing rates for the service. Billing occurs in 15-minute increments for the service provided to the participant.

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1915(b)(4) Waivers **Maryland Community First Choice 4.19B 1915 - K**
Community First Choice State Plan Option Reimbursement

- D. Personal Emergency Response System: The rate was based on existing rates for the service. There is a one unit maximum per installation and there is a one unit maximum per month for PERS maintenance/monitoring. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the participant's Plan of Service.
 - E. Supports Planning: The rate was developed based on pre-existing rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at <http://dbm.maryland.gov>. All providers of this service will be reimbursed at the same rate. Billing occurs in 15-minute increments for this service.
 - F. Financial Management Service: As defined per 42 CFR 441.545(b)(1), financial management activities must be made available to individuals with a service budget. The financial management entity is procured through state procurement regulations associated with competitive bidding.
- II. Non-State Plan CFC Services
- a. The following will be services permissible under CFC in the category of items that substitute for human assistance:
 - 1. Home delivered meals
 - a. Providers of this service are limited to those listed on page 8 and 8a of attachment 3.1 - K.
 - b. This service will be provided to the extent that it substitutes for human assistance and, along with personal assistance, is limited by the RUG allocated budget.
 - c. Meals are reimbursed based on the Department's fee schedule per meal and cannot exceed 2 meals daily.
 - 2. Accessibility Adaptations
 - a. Providers of this service are limited to those listed on page 9 and 10 of attachment 3.1 - K.
 - b. A unit is equal to one piece of equipment or item.
 - c. Reimbursement occurs on a fee for service basis, based on the rate in the fee schedule .
 - d. This expense will be capped at \$15,780.00 for every three-year period per participant.

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3. Environmental Assessments
 - a. Providers of this service are limited to those listed on page 8a of attachment 3.1-K.
 4. Technology that substitutes for human assistance
 - a. A unit is equal to one piece of equipment or item.
 - b. Included technology items are listed on pages 8a and 9 of attachment 3.1 - K
 - c. The Department will approve, for items costing more than \$1,000.00, based on multiple quotes from supports planners except as specified below.
 - d. In order to qualify for payment, each piece of technology shall meet applicable standards of manufacture, design, usage, and installation. Experimental technology or equipment is excluded.
 - e. Supports Planners are required to obtain multiple quotes from enrolled providers for individual units of service that exceed \$1,000.00, except in the case of a request for a repair to a stair glide with associated costs at or below \$1,500.00. Technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare, or the Medicaid State plan.
 - f. CFC may approve services that exceed this cost cap under circumstances when there is documentation that the additional services will reduce the ongoing cost of care or avert institutional care. Units of service may not exceed what is approved in the participant's plan of service.
- III. Transition Services - State Plan Service
- a. The Department will administer transition funds until such time as a contractor can be secured via a procurement.
 - b. Transition services will be covered when it is identified based on assessment of need and listed as a needed service in the participant's Recommended Plan of Care.
 - c. CFC transition services may be administered up to 60 calendar days post transition.
 - d. Transition services are limited to \$3,000 per transition.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☒	HCBS Respite Care COMMUNITY-BASED RESPITE CARE Community-based respite services are provided for a minimum of one hour and a maximum of six hours per day, and may not be billed on the same day as out of home respite. Effective July 1, 2024, a rate increase of 3% across community- based Behavioral Health services was implemented in the agency’s fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on “Fee Schedules”, and selecting “1915(i) Fee Schedule”. State developed fee schedule rates are the same for both governmental and private individual practitioners. The community-based respite care rate adheres to the CMS-accepted methodology for cost-based rates which includes salary, fringe benefits, indirect costs, and transportation costs. The rate was based on the following staffing assumptions: 68% billable time, 1 FTE respite worker with a caseload of 15, 0.15 FTE administrative staff (respite supervisor at .10 FTE and administrative support at .05 FTE). Payment for Community Based Respite Care service as outlined per Attachment 3.1-i pages 25-26 is reimbursed in accordance with the fee schedule referenced on page 57 paragraph two. Community Based Respite Care providers are defined per Attachment 3.1-i pages 26-27. OUT OF HOME RESPITE CARE

Out of Home respite services are provided on an overnight basis for a minimum of 12 hours. The service has a maximum of 24 units per year, subject to medical necessity criteria override. The service may not be billed on the same day as community-based respite.

Effective July 1, 2024, a rate increase of 3% across community- based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of <https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx>, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

State developed fee schedule rates are the same for both governmental and private individual practitioners.

The rate development was originally based on the Fiscal Year 2012 Maryland Interagency Rates Committee (IRC) rates for residential child care facilities and child placement agencies. The IRC is charged with developing and operating a rate process for residential child care and child placement agency programs that is fair, equitable and predictable, and is comprised of representatives from the Department of Budget and Management, Maryland Department of Health /Behavioral Health Administration, Department of Human Services/Social Services Administration, Department of Juvenile Services, Governor's Office for Children and the Maryland State Department of Education.

The IRC identifies programs as "preferred" or "non-preferred." The rate development was originally based on the average per diem rate for preferred programs including group homes, therapeutic group homes, and treatment foster care providers because these are comparable settings to out of home respite care.

Payment for Out Of Home Respite Care service as outlined per Attachment 3.1-i page 27- 28 is reimbursed in accordance with the fee schedule referenced on page 58 paragraph two. Out Of Home Respite Care providers are defined per Attachment 3.1-i pages 28-29.

For Individuals with Chronic Mental Illness, the following services:

HCBS Day Treatment or Other Partial Hospitalization Services



HCBS Psychosocial Rehabilitation

INTENSIVE IN-HOME SERVICES (IIHS) – EVIDENCE BASE PRACTICES (EBP)

The approved Intensive In-Home Services (IIHS) providers will bill the Maryland Department of Health (MDH) directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public IIHS providers will be reimbursed at the same rate.

An IIHS provider may bill for a week only if an IIHS activity occurred for the covered youth on at least one day of the billable week. A minimum of two (2) face- to-face contacts are required per week. At least one of the weekly contacts must be provided in-person. The service must be provided consistent with the State approved Evidence Based Practice or State approved promising practice model. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment and other family therapies cannot be charged at the same time. IIHS providers are expected to provide crisis response services for the youth on their caseload.

The rate development adheres to the CMS-accepted methodology for cost- based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current IIHS program. Cost estimates conform to our experience with programs similar to IIHS in Maryland, including the salaries paid.

Effective July 1, 2024, a rate increase of 3% across community-based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of <https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx>, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

The Department's reimbursement methodology for IIHS-EBP services was set as of October 1, 2014 and is effective for services on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners.

An evidence-based practice (EBP) is defined as a program, intervention or service that:

- Is recognized by MDH as an EBP for youth;
 - Are derived from rigorous, scientifically controlled research; and
 - Can be applied in community settings with a defined clinical population;
- Has a consistent training and service delivery model;
- Utilizes a treatment manual; and
- Has demonstrated evidence that successful program implementation results in improved, measurable outcomes for recipients of the service intervention.

The rate for the IIHS-EBP (and, in particular, the caseload used) was based on Functional Family Therapy, an established EBP in Maryland. The rate is higher for those programs that are identified as an EBP, in keeping with the established practice of different reimbursement rates for an EBP versus non- EBP service (e.g., Mobile Treatment Services and Assertive Community Treatment).

Payment for Intensive In-Home service as outlined per Attachment 3.1-i pages 21-22 and is reimbursed in accordance with the fee schedule referenced on page 59 paragraph one. Intensive In-Home providers are defined per Attachment 3.1-i pages 22-24.

INTENSIVE IN-HOME SERVICES (IIHS)—NON EVIDENCE BASED PRACTICE (NON EBP)

The approved Intensive In-Home Services (IIHS) providers will bill the Maryland Department of Health directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff.

Private and public IIHS providers will be reimbursed at the same rate.

An IIHS provider may bill for a week only if an IIHS activity occurred for the covered youth on at least one day of the billable week. A minimum of two (2) face-to-face contacts are required per week. At least one of the weekly contacts must be provided in-person. The service must be provided consistent with the State approved Evidence Based Practice or State approved promising practice model. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment and other family therapies cannot be charged at the same time. IIHS providers are expected to provide crisis response services for the youth on their caseload.

Effective July 1, 2024, a rate increase of 3% across community- based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services

provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of <https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx>, clicking on “Fee Schedules”, and selecting “1915(i) Fee Schedule”.

The Department’s reimbursement methodology for IIHS-Non EBP services was set as of October 1, 2014 and is effective for services on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners.

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current

IIHS program. Cost estimates conform to our experience with programs similar to IIHS in Maryland, including the salaries paid.

Payment for Intensive In-Home service as outlined per Attachment 3.1-i pages 21-22 is reimbursed in accordance with the fee schedule referenced on page 60 paragraph one. Intensive In-Home providers are defined per Attachment 3.1-i pages 22-24.

MOBILE CRISIS RESPONSE SERVICES

This service was discontinued as of 9/30/2020. Reserve for future use.

EXPRESSIVE AND EXPERIENTIAL BEHAVIORAL SERVICES

The approved expressive & experiential behavioral therapy providers will bill the Maryland Department of Health for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public expressive and experiential behavioral therapy providers will be reimbursed at the same rate.

Effective July 1, 2024, a rate increase of 3% across community-based Behavioral Health services was implemented in the agency’s fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of <https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx>, clicking on “Fee Schedules”, and selecting “1915(i) Fee Schedule”.

State developed fee schedule rates are the same for both governmental and private individual practitioners.

The following details the rate development for expressive and experiential behavioral therapy services. Expressive and Experiential Behavioral Therapy Services Providers must have a) A bachelor's or master's degree from an accredited college or university; and (b) Current registration in the applicable association. The applicable registrations and associations include the following:

- Art Therapist certified by the Art Therapy Credentials Board in the American Art Therapy Association or licensed as a Licensed Clinical Professional Art Therapist (LCPAT)

- Dance Therapist Registered or Academy of Dance Therapists Registered in The American Dance Therapy Association
- Certified by The Equine Assisted Growth and Learning Association (EAGALA) to provide services under the EAGALA model or The Professional Association of Therapeutic Horsemanship International (PATH Int.) (Formerly the North American Riding for the Handicapped Association (NARHA))
- Horticultural Therapist Registered by The American Horticultural Therapy Association
- Music Therapist-Board Certified by the Board for Music Therapists, Inc in the American Association for Music Therapy, Inc.
- Registered Drama Therapist or Board Certified Trainer in the National Association for Drama Therapy

These associations, registrations and certifications were identified as having comprehensive standards, continuing education requirements, and examinations. As such, the rate for this service has been aligned with the Medicaid rate for individual practitioners (licensed certified social worker- clinical, nurse psychotherapist, licensed clinical professional counselor, licensed clinical marriage and family therapist, and certified registered nurse practitioner-psychiatric) and are reimbursed in accordance with the fee schedule referenced on page 58 paragraph six. A differential is applied for fully licensed clinicians who also have certification versus non-licensed professionals who solely possess certification in one of the expressive and experiential therapies. The group rates were based on the C&A Group Psychotherapy Rates.

Payment for Expressive and Experiential Behavioral service as outlined per Attachment 3.1-i page 33 are reimbursed in accordance with the fee schedule referenced on page 60 paragraph eight. Expressive and Experiential Behavioral providers are defined per Attachment 3.1-i page 33-36.

FAMILY PEER SUPPORT

Effective July 1, 2024, a rate increase of 3% across community-based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of <https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx>, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

State developed fee schedule rates are the same for both governmental and private individual practitioners.

The rate development adheres to the CMS-accepted methodology for cost- based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current peer support programs. Cost estimates conform to our experience with peer support in Maryland.

Payment for Family Peer Support service as outlined per Attachment 3.1-i pages 29-30 are reimbursed in accordance with the fee schedule referenced on page 61 paragraph four. Family Peer Support providers are defined per Attachment 3.1-i pages 30-33.

YOUTH PEER SUPPORT

The agency's fee schedule rate was set as of April 1, 2025 and is effective for youth peer support services provided on or after that date. A link to the published fee

	schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on “Fee Schedules”, and selecting “1915(i) Fee Schedule”. State developed fee schedule rates are the same for both governmental and private individual practitioners. The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current peer support programs. Cost estimates conform to our experience with peer support in Maryland. Payment for Youth Peer Support services as outlined in Attachment 3.1-i page 35 are reimbursed in accordance with the fee schedule referenced on page 62 paragraph one. Youth Peer Support providers are defined per Attachment 3.1-i pages 36-37.
	☐ HCBS Clinic Services (whether or not furnished in a facility for CMI)
	☒ Other Services (specify below)
	CUSTOMIZED GOODS AND SERVICES This service was discontinued as of 9/30/2020. Reserve for future use.

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

Community Personal Assistance Services 4.19B
State Plan Option Reimbursement

- 1) Effective October 1, 2015, payments for community personal assistance services as defined per Attachment 3.1A page 31B shall be reimbursed in 15-minute units. Both government and non-government providers of community personal assistance services are reimbursed pursuant to the same fee schedule. The current fee schedule is published on the Department's website at: health.maryland.gov/providerinfo.
- 2) Participants choosing to self-direct will be able to set rates for personal assistance providers. Personal assistance providers for participants in the agency model are required to use the Department's Electronic Visit Verification (EVV) system. Personal assistance providers for participants in the self-directed model are required to use the EVV system of the Financial Management and Counseling Services contractor selected by the participant.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items 1-2 of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in items 1-2 of this attachment (see 3. above).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs: Part A MR Deductibles MR, NR Coinsurance

Part B MR Deductibles MR, NR Coinsurance

Other Part A MR Deductibles MR, NR Coinsurance

Medicaid

Recipients Part B MR Deductibles MR, NR Coinsurance

Dual Part A MR Deductibles MR, NR Coinsurance

Eligible

(QMB Plus)* Part B MR Deductibles MR, NR Coinsurance

"QMB Plus" is the CMS term for "Full Duals" their Medicare - and Medicaid expenses are covered by Medicaid.
There is not a separate coverage group for QMB Plus as opposed to QMB.

TN No. 06-03
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TN No. 92-11

NOV 29 2005
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACTState/Territory: Maryland**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE****Payment of Medicare Part A and Part B Deductible/Coinsurance**

Item 1 – For all dual Medicare and full Medicaid covered individuals (note: does not apply to QMB-only), the coinsurance payment for outpatient psychiatric services is the Medicare allowable amount, including any amount normally withheld as a psychiatric exclusion, less the amount paid by Medicare. The deductible payment will be the deductible amount determined by Medicare.

Item 2 – Payment for Part A coinsurance days for dually eligible nursing home recipients is the difference between the amount that Medicare paid and the Medicaid per diem statewide average payment for Nursing Facility Services up to a ceiling of the current coinsurance per diem rate as established by the Department of Health and Human Services.

Item 3 – For all dual Medicare and full Medicaid covered individuals, and QMB-only individuals, the coinsurance payment for Part B claims is the difference between the amount that Medicare paid and the Medicaid allowable-amount* up to the full Medicare coinsurance amount with the exception of Item 1 above and:

- Five-digit HCPCS Level II codes that begin with a letter of the alphabet – Medicaid will defer to Medicare pricing for these codes
- Anesthesiology services identified by 00100 to 01999 in the CPT coding book – Medicaid will defer to Medicare pricing for these codes
- Codes that are priced by report – certain codes cannot be priced in the computer system because they must be priced on a case by case basis - Medicaid will defer to Medicare in pricing for these codes
- Services only covered by Medicare – Medicaid will defer to Medicare pricing for these services
- Services provided by FQHCs - Medicaid will defer to Medicare pricing for these services
- Codes that have a Medicare modifier that is not recognized by Medicaid – sometimes Medicare has payment logic built into modifiers that we do not have in the Medicaid program – Medicaid will defer to Medicare pricing logic

* For professional fees for Medicaid recipients under the currently approved State Plan, the State pays approximately 80% of Medicare, but there are some codes where Medicaid pays up to 100% of Medicare or slightly less based on the need to attract certain specialists (example – obstetricians). Under the new methodology described in Item 3, Maryland Medicaid will only

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MarylandMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CAREPayment of Medicare Part A and Part B Deductible/Coinsurance

pay up to what Medicaid would have paid for the procedure code, but in no case more than what Medicare would have paid for the code. For example, if the Medicare rate for the code were \$100 and the Medicaid rate was \$80, Medicare would pay \$80 and Maryland Medicaid would pay nothing because we only pay up to the Medicaid rate. If the Medicare rate were \$100 and our rate for the code was \$90, then Medicare will pay \$80 and Maryland Medicaid will pay \$10.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Item 4: Ambulance and Wheelchair Van Services

The Ambulance and Wheelchair Van Services program covers only the coinsurance and deductible payments when Medicare covers the service as a primary payer. Providers are ambulance companies licensed in the state of Maryland and maintain appropriate licensure in the State of their primary location when their primary location is not Maryland.

Providers of ambulance and wheelchair van service must be enrolled with Medicare and Medicaid.

NOV 13 2014

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