

Table of Contents

| | |
|--|----------|
| Section 4 - General Program Administration | 6 |
| 4.1 Methods of Administration | 6 |
| 4.2 Hearings for Applicants and Recipients | 7 |
| 4.3 Safeguarding Information on Applicants and recipients | 8 |
| 4.4 Medicaid quality Control (MMIS) | 9 |
| 4.5 Medicaid Agency Fraud Detection and Investigation Program | 10 |
| 4.6 Reports | 11 |
| 4.7 Maintenance of Records | 12 |
| 4.8 Availability of Agency Program Manuals | 13 |
| 4.9 Reporting Provider Payments to IRS | 14 |
| 4.10 Free Choice of Providers | 15 |
| 4.11 Relations with Standard-Setting and Survey Agencies | 16 |
| (a) <i>Establishing the Office of Health Care Quality</i> | 16 |
| (b) <i>OHCQ responsible for establishing and maintaining standards</i> | 16 |
| (d) <i>State Department of Health and Mental Hygiene Office of Health Care Quality</i> | 17 |
| 4.12 Consultation to Medical Facilities | 18 |
| (a) <i>to hospitals, SNFs, Home Health, clinics, and laboratories</i> | 18 |
| (b) <i>Facilities providing services under 42 CFR 431.105(b)</i> | 18 |
| 4.13 Required Provider Agreement | 19 |
| (e) <i>Provide Education, Complete Documentation, and Maintain Advanced Directives</i> | 20 |
| 1(a) <i>Rights to make choices, and create Advance Directives</i> | 20 |
| 2(a–d) <i>Provision of info: admission to Hosp., SNFs, Home Health, Personal Care, Hospice</i> | 21 |
| 2(e) <i>At time of enrollment in Health Maintenance Organization</i> | 21 |
| 4.14 Utilization Control | 22 |
| (a) <i>Contract with Utilization and Quality Control peer Review Organization</i> | 22 |
| (b) <i>Inpatient Hospital Services</i> | 23 |
| <i>Utilization Review of Hospital, Long Term Care, and Community Services</i> | 24 |
| (c) <i>Control of Utilization of Inpatient Services in Mental Hospitals</i> | 25 |
| (d) <i>Control of Utilization of Skilled Nursing Facilities</i> | 26 |
| (e) <i>Control of Utilization in intermediate care facility services</i> | 27 |
| (f) <i>Control of Utilization in each Health Maintenance Organization</i> | 28 |
| 4.15 Inspection of Care ICFs, Inpatient Psychiatric Services, and Mental Hospitals | 29 |
| 4.16 Relations with State Health and Vocational Rehabilitation and Title V Grantees | 30 |
| 4.17 Liens and Adjustments or Recoveries | 31 |
| (a) <i>Liens</i> | 31 |
| (b) <i>Adjustments or Recoveries</i> | 32 |
| (1) <i>permanently institutionalized individuals</i> | 32 |
| (3) <i>medical assistance at age 55 or older</i> | 32 |
| (i) <i>Medical assistance for Medicare cost Sharing</i> | 33 |
| (ii) <i>Asset disregard - Attachment 2.6-A</i> | 34 |
| (c) <i>Adjustments or Recoveries: Limitations</i> | 35 |
| (d) <i>ATTACHMENT 4.17-description of contents</i> | 36 |
| (1) <i>Method of assessing: individual cannot reasonably discharged to home</i> | 36 |
| (2) <i>Son or Daughter has been providing care</i> | 36 |
| (3) <i>Definitions of key terms</i> | 36 |
| (4) <i>Waiving Estate Recovery</i> | 37 |
| (5) <i>When Adjustment / Recovery is not cost-effective</i> | 37 |

| | |
|--|----|
| (6) Collection Procedures | 37 |
| 4.18 Recipient Cost Sharing and Similar Charges | 38 |
| (b)(2)(i) No Deductible, coinsurance, copayment, or similar charge (Under Age 21) | 38 |
| (b)(3)(ii) Charges for services furnished apply to individuals 21 years or older | 40 |
| (b)(3)(iii) Attachment 4.18-A for categorically needy and qualified Medicare beneficiaries | 40 |
| (A) Service(s) for which charge applied | 40 |
| (B) Nature of charges imposed | 40 |
| (C) Amounts of and basis for determining charges | 40 |
| (D) Methods used to collect charges | 41 |
| (E) Inability to pay - Proof of inability to pay | 41 |
| (F) Implementing and Enforcing Exclusions from Cost sharing | 41 |
| (G) Cumulative maximum | 41 |
| (c) Medically Needy | 43 |
| (2)(i) No deduction, coninsurance, copayment or similar charge under age 21 | 43 |
| (3)(ii) Charges apply to services furnished to individuals 21 or older | 45 |
| 3(iii) Medically Needy and Other optional groups | 46 |
| (A) Service(s) for which charge applied | 46 |
| (B) Nature of charges imposed | 46 |
| (C) Amounts of and basis for determining charges | 46 |
| (D) Methods used to collect charges | 46 |
| (E) Inability to pay - Proof of inability to pay | 47 |
| (F) Implementing and Enforcing Exclusions from Cost sharing | 47 |
| (G) Cumulative maximum | 47 |
| 4.19 Payment for Services- Inpatient Hospital Services | 48 |
| (a) Attachment 4.19-A Methods and standards for determining rates for payment | 48 |
| Inappropriate level of care days | 48 |
| Rates set by the Maryland Health Services Cost Review Commission | 48 |
| (b) FQHCs | 49 |
| rural health clinics | 49 |
| (c) Reserving a bed during temporary absence from an inpatient facility | 50 |
| (d) Payments to SNFs and ICFs | 51 |
| (2) No SNF payments to swing-bed hospital | 51 |
| (3) No payment for ICF services to a swing-bed hospital | 51 |
| (e) Timely payment of all claims | 52 |
| (f) Providers must meet Medicaid qualifications to participate | 53 |
| (g) Appropriate audit of records | 54 |
| (h) Documentation and availability of payments | 55 |
| (i) Payments are sufficient so that accessibility same as for general pop. | 56 |
| (j) Public Notice of Changes | 57 |
| (k) Emergency MA for alien not lawfully admitted for permanent residence | 57 |
| (m) Reimbursement for Vaccines under the Pediatric Immunization Program | 58 |
| (ii) Regional maximum payment rate established by the DHHS Secretary | 58 |
| (iii) access to immunizations is assured | 58 |
| 4. 20 Direct Payments to Certain Recipients for Physicians' or Dentists Services | 59 |
| 4.21 Prohibition Against Reassignment of Provider Claims | 60 |
| 4.22 Third Party Liability | 61 |
| (b) ATTACHMENT 4.22-A (Description of Contents) | 61 |
| (1) (1) Frequency of Data exchange diagnosis and trauma codes | 61 |
| (3) Follow up on information obtained through state motor vehicle accident report | 61 |
| (4) Paid claims identified – highest third party collections | 61 |
| (c) Providers are required to bill liable 3rd parties | 62 |
| (d) ATTACHMENT 4.22-B | 62 |
| (1) Provider compliance with 3rd party billing | 62 |

| | |
|--|----|
| (2) Threshold for seeking recovery | 62 |
| (3) Method for determining when to seek recovery | 62 |
| (f) Cooperative Agreements for enforcement of Rights to and collection of 3rd party benefits | 63 |
| (g) Laws relating to medical child support under section 1908 | 63 |
| (h) Cost effectiveness of employer-based group health plan | 63 |
| 4.23 Use of Contracts | 64 |
| 4.24 Standards for Payment to NFs and ICFs for Scvs for the Mentally Retarded | 65 |
| 4.25 Program for Licensing Administrators of Nursing Homes | 66 |
| 4.26 Drug Utilization Review Program | 67 |
| (a)(1) Outpatient drug claims | 67 |
| (a)(2) Outpatient drugs meet the following criteria | 67 |
| (b) Reduction of Fraud | 67 |
| (c) Assess data use against predetermined standards | 67 |
| (d) Retrospective DUR for SNFs | 68 |
| (e)(1) Prospective review of drug therapy | 68 |
| (e)(2) Prospective DUR includes screening | 68 |
| (e)(3) Includes counseling | 68 |
| (f)(1) Retrospective DUR | 68 |
| (f)(2) Assesses drug use against explicit predetermined standards | 69 |
| (f)(3) DUR is run through State DUR Board | 69 |
| (g)(1) DUR Board is under contract with a private firm | 69 |
| (g)(2) DUR Board membership includes Health professionals | 69 |
| (g)(3) Activities of DUR Board | 69 |
| (g)(4) Interventions include | 70 |
| (h) Annual DUR report to the Secretary | 70 |
| (i)(1) Point-of-sale electronic claims management system | 70 |
| (i)(2) Prospective DUR will use electronic POS | 70 |
| (j) Hospital dispensation of outpatient drugs | 70 |
| (k) DUR Program claim review limitations | 71 |
| 4.27 Disclosure of Survey Information and Provider Contractor Evaluation | 72 |
| 4.28 Appeals Process for SNF and Intermediate Care Facility | 73 |
| 4.29 Conflict of Interest Provisions | 74 |
| 4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals | 75 |
| (a) Broader sanctions | 75 |
| (b)(1) Exclusion from participation | 76 |
| (2)(b) No payment / participation for a determined period | 77 |
| (c)(1) Prompt notification to HCFA | 77 |
| (c)(2) Access to information regarding sanctioned providers | 77 |
| 4.31 Disclosure of Information by Providers and Fiscal Agents | 78 |
| 4.32 Income and Eligibility Verification System | 78 |
| 4.33 Medicaid Eligibility Cards for Homeless Individuals | 79 |
| 4.34 Systematic Alien Verification for Entitlements | 80 |
| 4.35 Remedies for SNF/ICF that Do Not Meet Requirements | 81 |
| (a) Fulfillment of 1919 (h) (2) (A) through (D) | 81 |
| (b) Remedies used by the State | 81 |
| (d) Incentive programs | 81 |
| Enforcement of Compliance for Nursing Facilities | 82 |
| (a) Enforcement action | 82 |
| (i) Notice for penalties (excluding civil monetary) | 82 |
| (ii) Civil Monetary penalty notifications | 82 |
| (iii) Immediate Jeopardy notifications and all others | 82 |
| (iv) Notification of Termination | 82 |

| | |
|--|----|
| (b) Factors to be Considered in Selecting Remedies | 82 |
| c) Application of Remedies | 83 |
| (i) Immediate jeopardy | 83 |
| (ii) Denial of payment for new admissions - non compliance | 83 |
| (iii) Denial of payment - substandard care 3 surveys | 83 |
| (d) Available Remedies | 83 |
| 4.36 Required Coordination Between the Medicaid and WIC Programs | 85 |
| 4.37 Reimbursements for Prescribed Drugs | 86 |
| 4.41 Resident Assessment for Nursing Facilities | 87 |
| (a) Specified instrument for assessing SNF / NF residents | 87 |
| (b) Transmittal #241 of State Operations Manual | 87 |
| 4.42 Employee Education About False Claims Recoveries | 88 |
| 4.46 Provider Provider Screening and Enrollment | 93 |
| Provider Screening | 93 |
| Enrollment and Screening of Providers | 93 |
| Verification of Provider Licenses | 93 |
| Revalidation of Enrollment | 93 |
| Termination or Denial of Enrollment | 93 |
| Reactivation of Provider Enrollment | 93 |
| Appeal Rights | 94 |
| Site Visits | 94 |
| Criminal Background Checks | 94 |
| Federal Database Checks | 94 |
| National Provider Identifier | 94 |
| Screening Levels for Medicaid Providers | 94 |
| Application Fee | 94 |
| Temp Moratorium: of New Providers / Suppliers | 94 |
| 4.50 Medicaid Recovery Audit Contractor Program | 91 |
| Exception from Recovery audit contractors (RACs) | 91 |
| FFS Interim Payments During Change Healthcare Cybersecurity Incident | 95 |
| FFS Interim Payments due to Extenuating Circumstances | 96 |

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

HCFA-AT-80-38 (BPP)
MAY 22, 1980

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Maryland

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

TN No. 88-1
Supersedes
TN No. 76-19

Approval Date JUL 15 1988

Effective Date JUL 01 1987

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 431.202
AT-79-29
AT-80-34

4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

TN # 76-19
Supersedes
TN # _____

Approval Date 8-10-76 Effective Date 4-1-76

Revision: HCFA-AT-87-9 (BERC)
AUGUST 1987

OMB No.: 0938-0193

State/Territory: Maryland

Citation
42 CFR 431.301
AT-79-29

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

TN No. 88-5
Supersedes
TN No. 76-19

Approval Date 7/7/88

Effective Date 10 15 1987

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Maryland

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of
the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

- (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
- (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

Yes.

Not applicable. The State has an approved Medicaid Management Information System (MMIS).

TN No. 88-1
Supersedes
TN No. 86-8

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Effective Date JUL 01 1987

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: MARYLAND

Citation
42 CFR 455.12
AT-78-90
48 FR 3742
52 FR 48817

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

TN No. 89-13
Supersedes
TN No. 83-25

Approval Date

JAN 25 1989

Effective Date

DEC 31 1988

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

TN # 78-3
Supersedes
TN # _____

Approval Date 3-10-78

Effective Date 12-31-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TN # 78-3

Supersedes

TN # _____

Approval Date 3-10-78 Effective Date 12-31-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 431.18 (b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN # 74-7
Supersedes
TN # _____

Approval Date 10-31-75 Effective Date 1-1-74

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN # 74-7
Supersedes
TN # _____

Approval Date 10-31-75 Effective Date 1-1-74

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: MARYLAND

Citation

42 CFR 431.51
AT-78-90
46 FR 48524
48 FR 23212
1902 (a) (23)
of the Act
P.L. 100-93
(section 8(f))
P.L. 100-203
(section 4113)

4.10 Free Choice of Providers

- (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.
- (b) Paragraph (a) does not apply to services furnished to an individual--
- (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
 - (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or
 - (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act.
- (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

TN No. 95-9
Supersedes
TN No. 88-9

Approval Date

MAR 17 1995

Effective Date

MAR 10 1995

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Maryland

Citation 4.11 Relations with Standard-Setting and Survey Agencies

42 CFR 431.610
AT-78-90
AT-80-34

- (a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is
The State Department of Health and Mental Hygiene; Office of Health Care Quality
- (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are):
Same as above
- (c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

TN # 11-06
Supersedes TN # 74-07

Approval Date JUL 29 2011 Effective Date APRIL 1, 2011

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Maryland

Citation

42 CFR 431.610
AT-78-90
AT-89-34

4.11(d) The State Department of Health and Mental Hygiene:
Office of Health Care Quality (agency) which is the
State agency responsible for licensing health
institutions. determines if institutions and agencies meet
the requirements for participation in the Medicaid
program. The requirements in 42 CFR 431.610(e), (f),
and (g) are met.

TN # 11-06
Supersedes TN # 74-07

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Revision: HCFA-MT-80-36 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 431.105 (b)
AT-78-90

4.12 Consultation to Medical Facilities

- (a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105 (b).
- (b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

Yes, as listed below:
Pre-Paid Health Plans

Not applicable. Similar services are not provided to other types of medical facilities.

TN # 24-1
Supersedes
TN # _____

Approval Date 9-17-74 Effective Date 12-31-73

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

OMB No.: 0938-

State/Territory: Maryland

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- 42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
- 42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
- 42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
- 1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

TN No. 92-11
Supersedes 88-1 Approval Date JUN 05 1992 Effective Date NOV 01 1991
TN No. 88-1

HCFA ID: 7982E

45(a)

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

State/Territory: Maryland

Citation

1902(a)(58)

1902(w)

4.13

(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:
 - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
 - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
 - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
 - (e) Ensure compliance with requirements of State Law (whether

TN No. 92-12

Supersedes

Approval Date

DEC 02 1991

Effective Date

OCT 01 1991

TN No. _____

HCFA ID: 7982E

45(b)

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

State/Territory: Maryland

statutory or recognized by the courts) concerning advance directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:
- (a) Hospitals at the time an individual is admitted as an inpatient.
- (b) Nursing facilities when the individual is admitted as a resident.
- (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
- (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
- (e) Health maintenance organizations at the time of enrollment of the individual with the organization.
- (3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

____ Not applicable. No State law or court decision exist regarding advance directives.

TN No. 92-12

Supersedes

Approval Date

DEC 02 1991

Effective Date

OCT 01 1991

TN No. _____

HCFA ID: 7982E

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No: 0938 - 0193

State/Territory: Maryland

Citation

42 CFR 431.630
42 CFR 456.2
50 FR 15312

4.14 Utilization Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

Directly

1902 (a) (30) (C)
And 1902 (d) of the
Act, P.L. 99-509
(Section 9431)

By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO—

- (1) Meets the requirements of §434.6 (a);
- (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
- (3) Identifies the services and providers subject to PRO review;
- (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
- (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1902 (a) (30) (C)
And 1902 (d) of the
Act, P.L. 99-509
(Section 9431)

Quality review requirements described in section 1902 (a) (30) (C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designated under 42 CFR Part 462.

By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

TN # 11-05
Supersedes TN # 89-13

Approval Date AUG 8 2011

Effective Date APRIL 1, 2011

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Marvland

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

All hospitals (other than mental hospitals).

Those specified in the waiver.

No waivers have been granted.

TN No. 86-2
Supersedes
TN No. 83-6

Approval Date SEP 12 1985

Effective Date 7/1/85

HCFA ID: 0048P/0002P

Utilization Review of Hospital, Long Term Care and Community Services

Maryland's Single State Agency meets the requirements of utilization control as specified in 42 CFR §§431.630 and 456.2 and as specified in 42 CFR Part 456, Subpart C and F.

The Single State Agency has entered into a contract with a Quality Improvement Organization (QIO) designated under Part B of Title XIX to perform review of Medicaid services not inconsistent with those activities performed for review of Title XVIII services. Review is conducted as specified in the Utilization Control Plan for Utilization Review of Selected Institutional and Community Services Reimbursed by the Maryland Medical Assistance Program which is incorporated into the contract between the Single State Agency and the Utilization Control Agent (UCA). ICF/MR Facilities are not included under this contract.

The Utilization Control Agent shall successfully deliver and be charged with the responsibility of conducting utilization control to ensure that:

- a. Medical services are authorized only when medically necessary;
- b. Medical services provided in a hospital on an inpatient basis are authorized only when such services cannot be effectively provided on an outpatient basis or more effectively and efficiently in a facility of a different type;
- c. Medical services provided in a nursing facility, chronic hospital, or in a community-based program are authorized only when an individual is determined to be medically eligible for those services;
- d. Medical services provided to Medicaid recipients meet professionally recognized standards of quality;
- e. All authorized medical services are provided in an effective and efficient manner; and
- f. Abuses of utilization or payment are identified and reported to the Department.

The contract provides for the maintenance of records pertaining to determinations made under the Utilization Control Plan in accordance with State and Federal laws. The contract provides that no utilization control function can be subcontracted without the written consent of the Single State Agency. Performance of review functions specified in the Utilization Control Plan is monitored by the Office of Health Services. Regarding hospital services, the Office of Health Services monitors and evaluates the UCA's performance by pre-payment review of all invoices and accompanying UCA certification documents for hospital inpatient services provided to Title XIX recipients.

Revision: HCFA-PM-85-7 (BERC)
JULY 1985

OMB No.: 0938-0193

State/Territory:
Maryland

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of the utilization of inpatient services in mental hospitals.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

All mental hospitals

Those specified in the waiver.

No waivers have been granted

Not applicable. Inpatient services in mental hospitals are not provided under this plan.

TN # 11-05
Supersedes TN # 86-08

Approval Date AUG 8 2011 Effective Date APRIL 1, 2011

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Maryland

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

All skilled nursing facilities.

Those specified in the waiver.

No waivers have been granted.

TN No. ~~96-1~~
Supersedes
TN No. 85-6

Approval Date 10 1985

Effective Date 7/1/85

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

OMB No: 0938 - 0193

State: Maryland

Citation
42 CFR 456.2
50 FR 15312

- 4.14 (e) The Medicaid agency meets the requirements of section 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:
- Facility-based review.
 - Direct review by personnel of the medical assistance unit of the State agency.
 - Personnel under contract to the medical assistance unit of the State agency.
 - Utilization and Quality Control Peer Review Organizations. | * |
 - Another method as described in ATTACHMENT 4.14-A
 - Two or more of the above methods ATTACHMENT 4.14-B describes the circumstances under which each method is used
 - Not applicable. Intermediate care facility services are not provided under this plan.

NOTE: MD is checking N/A because this page is out of date. We propose CMS updates the page to reflect that ICF and Skilled is now NF. Maryland uses a QIO to review NFs.

| * | This excludes ICF/MR Facilities which are subject to facility and Inspection of care based review.

TN # 11-05
Supersedes TN # 86-02

Approval Date AUG 8 2011 Effective Date APRIL 1, 2011

Revision: HCFA-PM-85-4 (BERC)
MARCH 1987

OMB No: 0938 – 0193

State/Territory: Maryland

Citation

1902 (a) (30)
and 1902 (d) of
the Act. P.L. 99-
509 (Section
9431)

- 4.14 (f) The Medicaid agency meets the requirements of section 1902 (a) (30) of the Act for control of the utilization of services furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality review are preformed annually by:
- A Utilization and Quality Control Peer Review Organization designed under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
 - A private accreditation body.

TN # 11-05
Supersedes TN # 88-01

Approval Date AUG 8 2011 Effective Date APRIL 1, 2011

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: MARYLAND

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part
456 Subpart
I, and
1902(a)(31)
and 1903(g)
of the Act

_____ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

_____ ICFs/MR;

_____ Inpatient psychiatric facilities for recipients under age 21; and

_____ Mental Hospitals.

42 CFR Part
456 Subpart
A and
1902(a)(30)
of the Act

X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

_____ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

_____ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

_____ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

TN No. 93-23
Supersedes
TN No. 89-18

Approval Date

APR 22 1993

Effective Date

JAN 01 1993

HCFA ID: _____

Revision: HCSA-AT-80-36 (RPP)
May 22, 1980

State Maryland

Citation
42 CFR 431.615 (c)
AT-78-90

4.16 Relations with State Health and Vocational
Rehabilitation Agencies and Title V
Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

TN # 76-10
Supersedes
TN # _____

Approval Date 12-30-75 Effective Date 1-1-76

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Citation (s)

42 CFR 433.36 (c)
1902(a) (18) and
1917(a) and (b) of
The Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

X The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

X The State imposes liens on real property on account of benefits incorrectly paid.

X The State imposes TEFRA liens 1917 (a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

 The State imposes liens on both real and personal property of an individual after the individual's death.

TN No.: 10-14
Supersedes
TN No.: 86-17

Approval Date: MAR 14 2011 Effective Date: OCTOBER 1, 2010

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

Recover for all approved Medical Assistance, for Medicaid recipients aged 55 and over, except for Medicare cost sharing as specified at section 4.17(b)(3)-(Continued).

TN No.: 10-16
Supersedes
TN No.: 86-17

Approval Date: MAR 14 2011 Effective Date: OCTOBER 1, 2010

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

TN No.: 10-14
Supersedes
TN No.: NEW

Approval Date: MAR 14 2011 Effective Date: OCTOBER 1, 2010

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Citation (s)

- The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.
- The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset and resource disregard must select this entry. These five States may either check this entry or one of the following entries.)
- The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.
- The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:
- If an individual covered under a long-care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

TN No.: 10-14
Supersedes
TN No.: 09-02

Approval Date: MAR 14 2011 Effective Date: OCTOBER 1, 2010

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Citation (s)

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b) (2) of the Act and regulations at 42 CFR §433.36(h)-(i).

- (1) Adjustments or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustments or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
 - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
 - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

TN No.: 10-14
Supersedes
TN No.: NEW

Approval Date: MAR 14 2011 Effective Date: OCTOBER 1, 2010

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Citation (s)

(d) ATTACHMENT 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36 (d).
- (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
 - estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangements).
 - individual's home,
 - equity interest in the home.
 - Residing in the home for at least 1 or 2 years,
 - on a continuous basis,
 - discharge from the medical institution and return home, and
 - lawfully residing.

TN No.: 10-14
Supersedes
TN No.: NEW

Approval Date: MAR 14 2011 Effective Date: OCTOBER 1, 2010

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost effectiveness.

- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

TN No.: 10-14
Supersedes

Approval Date: MAR 14 2011 Effective Date: OCTOBER 1, 2010

TN No.: NEW

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

OMB No.: 0938-

State/Territory: Maryland

Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51
through 447.58

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b)
of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

TN No. 92-11

Supersedes

TN No. 91-5

Approval Date

JUN 05 1992

Effective Date

NOV 01 1991

HCFA ID: 7982E

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

OMB No.: 0938-

State/Territory: Maryland

Citation 4.18(b)(2) (Continued)

42 CFR 447.51
through
447.58

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

1916 of the Act,
P.L. 99-272,
(Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

TN No. 92-11 Approval Date MAY 05 1992 Effective Date NOV 01 1991
Supersedes
TN No. 91-5

HCFA ID: 7982E

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

OMB No: 0938-

State/Territory: Maryland

Citation 4.18 (b) (3) (Continued)

42 CFR 447.51
through
447.48

Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b) (2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

18 or older

19 or older

20 or older

21 or older

Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

42 CFR 447.51
through 447.58

(iii) For the categorically needy, and qualified Medicare beneficiaries, Attachment 4.18-A specifies the:

(A) Service (s) for which charge (s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount (s) of and basis for determining the charge (s);

TN No. 05-02 Approval Date: NOV 15, 2004 Effective Date: NOV 1, 2004
Supercedes
TN No. 92-11

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

OMB No: 0938-

State/Territory: Maryland

(D) Method used to collect the charge (s);

Hospitals will be responsible to collect copay from the recipients. If the individual declares inability to pay at the time of service, the hospital may not deny service.

42 CFR 447.51
through 447.58

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers; if an individual declares that he/she is unable to pay the charge at the time of services, the hospital must accept that assertion as proof of inability to pay

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

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b); and

Hospitals are prohibited from charging copay on services meeting the requirements in 42 CFR 447.53 (b) (4) and for screening required to determine if emergency services are needed. In accordance with 4.18 (b), providers will be notified that no copayment will be charged for children under 21 years and pregnant women and individuals seeking family planning. Institutionalized individuals and individuals in hospice will not be charged the copayments. This requirement will be monitored through hotline complaints. All complaints will be investigated and resolved.

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a specified time period.

√ Not applicable. There is no maximum.

TN No. 05-02 Approval Date: NOV 15, 2004 Effective Date: NOV 1, 2004
Supercedes
TN No. 92-11

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

OMB No.: 0938-

State/Territory: Maryland

Citation

1916(c) of
the Act

4.18(b)(4)

A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.

1902(a)(52)
and 1925(b)
of the Act

4.18(b)(5)

For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.

1916(d) of
the Act

4.18(b)(6)

A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

TN No. 92-11

Supersedes

TN No. 87-10

Approval Date

JUN 05 1992

Effective Date NOV 01 1991

HCFA ID: 7982E

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

OMB No.: 0938-

State/Territory: Maryland

Citation 4.18(c) Individuals are covered as medically needy under the plan.

42 CFR 447.51 through 447.58

(1) An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

JUN 05 1992

TN No. 92-11
Supersedes 91-5 Approval Date _____ Effective Date NOV 01 1991

HCFA ID: 7982E

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

OMB No.: 0938-

State/Territory: Maryland

Citation 4.18 (c)(2) (Continued)

- 42 CFR 447.51 through 447.58
- (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.
- (iii) All services furnished to pregnant women.
- Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- 1916 of the Act, P.L. 99-272 (Section 9505)
- (vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.
- 447.51 through 447.58
- (viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.
- Not applicable. No such charges are imposed.

TN No. 92-11

Supersedes

TN No. 91-5

Approval Date

JUN 05 1992

Effective Date

NOV 01 1991

HCFA ID: 7982E

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

OMB No: 0938-

State/Territory: Maryland

Citation 4.18 (c) (3)

Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b) (2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

18 or older

19 or older

20 or older

21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

TN No. 05-02 _____

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

TN No. 92-11

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

OMB No. : 0938-

State/Territory: Maryland

Citation 4.18 (c) (3) (Continued)

447.51 through 447.58

(i). For the medically needy, and other optional groups,
Attachment 4.18-C specifies the:

- (A) Service (s) for which charge (s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount (s) of and basis for determining the charge (s);
- (D) Method used to collect the charge (s);

TN # 11-07
Supersedes TN # 05-02

Approval Date JUL 29 2011 Effective Date APRIL 1, 2011

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

OMB No. : 0938-

State/Territory: Maryland

Citation 4.18 (c) (3) (iii) (Continued)

447.51 through 447.58

- (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers; if an individual declares that he/she is unable to pay the charge at the time of services, the hospital must accept that assertion as proof of inability to pay
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

√ Not applicable. There is no maximum.

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

OMB No.: 0938-

State/Territory: Maryland

Citation
42 CFR 447.252
1902 (a) (13)
and 1923 of
the Act

4.19 Payment for Services

- (a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902 (a) (13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

- Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act.
- Inappropriate level of care days are covered.

Section 4.19 Payment for Services (a), (above), applies to all hospitals except acute general hospitals. The Medicaid Agency reimburses for inpatient hospital services in acute general hospitals at rates set by the Maryland Health Services Cost Review Commission pursuant to a waiver issued by the Health Care Financing Administration (Contract No. 600-76-0140).

TN # 11-06
Supersedes TN # 92-11

Approval Date JUL 29 2011 Effective Date APRIL 1, 2011

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

OMB No.: 0938-

State/Territory: Maryland

- Citation 4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:
- 42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902(a)(13)(E)
1903(a)(1) and
(n), 1920, and
1926 of the Act
- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
 - (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

TN No. 92-11 Approval Date JUN 05 1992 Effective Date NOV 01 1991
Supersedes
TN No. 91-15

HCFA ID: 7982E

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 447.40
AT-78-90

4.19 (c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

Yes. The State's policy is described in ATTACHMENT 4.19-C.

No.

TN # 78-3
Supersedes
TN # _____

Approval Date 3-10-78 Effective Date 12-31-77

Revision: HCFA-PM-87-9 (BERC)
AUGUST 1987

OMB No.: 0938-0193

State/Territory: Maryland

Citation

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 (d)

- (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

- (3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

- (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

TN No. 88-5
Supersedes
TN No. 84-8

Approval Date 9/7/87

Effective Date OCT 15 1987

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BFP)
May 22, 1980

State MARYLAND

Citation
42 CFR 447.45 (c)
AT-79-50

4.19 (e) The Medicaid agency meets all requirements
of 42 CFR 447.45 for timely payment of
claims.

ATTACHMENT 4.19-E specifies, for each
type of service, the definition of a
claim for purposes of meeting these
requirements.

TN # 81-3
Supersedes
TN # _____

Approval Date 12/18/80 Effective Date 7/1/80

SEP 4 1980

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Maryland

Citation

42 CFR 447.15

AT-78-90

AT-80-34

48 FR 5730

4.19 (f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

TN No. 88-1
Supersedes
TN No. 83-21

Approval Date JUL 15 1988

Effective Date JUL 01 1987

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 447.201
42 CFR 447.202
AT-78-90

4.19(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

TN # 80-2
Supersedes
TN # _____

Approval Date 1-8-80

Effective Date 9-6-79

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 447.201
42 CFR 447.203
AT-78-90

4.19(h) The Medicaid agency meets the requirements of 42 CFR 446.203 for documentation and availability of payment rates.

TN # 80-2
Supersedes
TN # _____

Approval Date 1-8-80

Effective Date 9-6-79

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 447.201
42 CFR 447.204
AT-78-90

4.19(i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

TN # 80-2
Supersedes _____
TN # _____

Approval Date 1-8-80

Effective Date 9-6-79

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

OMB No.: 0938-

State: Maryland

Citation

| | | |
|----------------------------------|---------|--|
| 42 CFR 447.201 and 447.205 | 4.19(j) | The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates. |
| 1903(v) of the Act | (k) | The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act. |

TN No. 92-11 Approval Date JUN 05 1992 Effective Date 1991
Supersedes
TN No. 88-5

HCFA ID: 7982E

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: Maryland

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928 (c) (2) (C) (ii)
of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928 (c) (2) (C) (ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows:

(ii) The State:

X sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

Each child is assigned a primary medical care provider. These providers are responsible for providing EPSDT services, including immunizations.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for
Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

Yes, for physicians' services
 dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

Not applicable. No direct payments are made to recipients.

TN # 78-3
Supersedes
TN # _____

Approval Date 3-10-78 Effective Date 12-31-77

Revision: HCFA-AT-81-34 (BPP)

10-81

State Maryland

Citation **4.21 Prohibition Against Reassignment of Provider Claims**

42 CFR 447.10(c)
AT-78-90
46 FR 42699

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 82-4
Supersedes
TN # 78-12

Approval Date 12-4-81

Effective Date 7-1-81

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: MARYLAND

Citation

4.22 Third Party Liability

- 42 CFR 433.137 (a) The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
 - (2) 42 CFR 433.145 through 433.148.
 - (3) 42 CFR 433.151 through 433.154.
 - (4) Sections 1902(a)(25)(H) and (I) of the Act.
- 1902(a)(25)(H) and (I) of the Act
- 42 CFR 433.138(f) (b) ATTACHMENT 4.22-A --
- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
 - (2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
 - (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and
 - (4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.
- 42 CFR 433.138(g)(1)(ii) and (2)(ii)
- 42 CFR 433.138(g)(3)(i) and (iii)
- 42 CFR 433.138(g)(4)(i) through (iii)

TN No. 94-12 Approval Date JUN 23 1994 Effective Date JUL 01 1994
Supersedes
TN No. 90-10

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: MARYLAND

Citation

- 42 CFR 433.139(b)(3) (ii)(A) (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
- (d) ATTACHMENT 4.22-B specifies the following:
- 42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
- 42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
- 42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
- 42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

TN No. 94-12
Supersedes 90-10 Approval Date JUN 23 1994 Effective Date JUL 01 1994
TN No. 90-10

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: MARYLAND

Citation
42 CFR 433.151 (a)

4.22 (continued)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

State title IV-D agency. The requirements of 42 CFR 433.152 (b) are met.

Other appropriate State agency (s) --

Other appropriate agency (s) of another State --

Courts and law enforcement officials

1902 (a) (60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual. Section 3910

The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C

TN # 11-09
Supersedes TN # 94-12

Approval Date SEP 9 2011 Effective Date 4/1/2011

Revision: HCFA-AT-84-2 (BERC)
01-84

State _____

Citation
42 CFR Part 434.4
48 FR 54013

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

TN # 34-10
Supersedes
TN # 80-9

Approval Date 8/8/84 Effective Date 9/1/84

Revision: HCFA-PM-94-2 (BPD)
April 1994

State/Territory: MARYLAND

Citation

42 CFR 442.10
and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34
52 FR 32544
P.L 100-203
(Sec. 4211)
54 FR 5316
56 FR 48826

4.24 Standards for Payments for Nursing Facility
and Intermediate Care Facility for the Mentally
Retarded Services

With respect to nursing facilities and
intermediate care facilities for the mentally
retarded, all applicable requirements of
42 CFR, Part 442, Subparts B and C are met.

_____ Not applicable to intermediate care
facilities for the mentally retarded;
such services are not provided under this
plan.

TN No. 95-14

Approval Date MAY 31 1995

Effective Date 4/1/95

Supersedes

TN No. ~~81-18~~

Revision: BOFA-MT-80-38 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN # 74-1
Supersedes
TN # _____

Approval Date 9-17-74 Effective Date 12-31-73

Revision: HCFA-PM- (MB)

State/Territory: MARYLANDCitation1927(g)
42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b) and
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d)and(f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

TN No. 93-25

Supersedes

Approval Date

MAY 20 1993

Effective Date

APR 01 1993TN No. 93-23

State/Territory: MARYLAND

Citation

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

- Prospective DUR
- Retrospective DUR.

1927(g)(2)(A)
42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b),
(1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705 (c)
and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

TN No. 93-25

Supersedes

TN No. 93-23

Approval Date

MAY 20 1993

Effective Date

APR 01 1993

State/Territory: MARYLAND

Citation

927(g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)

G.1. The DUR program has established a State DUR Board either:

- Directly, or
- Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

TN No. 93-25

Supersedes

TN No. 93-23

Approval Date

MAY 20 1993

Effective Date

APR 01 1993

State/Territory: MARYLANDCitation

1927 (g) (3) (C)
42 CFR 456.711
(a)-(d)

- G. 4. The interventions include in appropriate instances:
- Information dissemination
 - Written, oral, and electronic reminders
 - Face-to-Face discussions
 - Intensified monitoring/ review of prescribers/dispensers

1927 (g) (3) (D)
42 CFR 456.712
(A) and (B)

- H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, and procedures as described in the report.

1927 (h) (1)
42 CFR 456.722

√

- I. 1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:
- real time eligibility verification
 - claims data capture
 - adjudication of claims
 - assistance to pharmacists, etc. applying for and receiving payment.

1927 (g) (2) (A) (i)
42 CFR 456.705 (b)

√

2. Prospective DUR is performed using an electronic point of sale drug claims processing system.

1927 (j) (2)
42 CFR 456.703 (c)

- J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

* U.S. G.P.O.: 1993-342-239:80043

TN # 11-06
Supersedes TN # 93-25

Approval Date JUL 29 2011

Effective Date APRIL 1, 2011

State/Territory: MARYLANDCitation

Public Law 115-271
 1902(oo) [42 U.S.C 1396(a)]
 Section 1004 of the Substance
 Use-Disorder Prevention that
 Promotes Opioid Recovery and
 Treatment for Patient and
 Community Act (SUPPORT Act)

- K. The DUR Program includes claim review limitations on:
- Prospective safety edits on opioid claims to review day's supply, early refills, duplicate fills and quantity limitation for clinical appropriateness.
 - Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioid medication to limit the daily MME.
 - Retrospective reviews on opioid claims exceeding these above limitations on a regular basis.
 - Retrospective reviews on concurrent use of opioids and benzodiazepines/antipsychotics on a regular basis.

Programs to monitor antipsychotic medications to children:

- Antipsychotics medications are reviewed for clinical appropriateness for all children up to age of 18 based on approved indications and clinical guidelines.

Fraud and Abuse Identification Requirements

- The DUR Program includes process that identifies potential fraud, waste or abuse of controlled substances by enrolled participants, health care providers and pharmacies.

Revision: HCFA-AT-80-38 (BFD)
May 22, 1980

State Maryland

Citation
42 CFR 431.115 (c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider
or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

TN # 80-7
Supersedes
TN # _____

Approval Date 2-28-80

Effective Date 10-15-79

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: MARYLAND

Citation 4.28 Appeals Process for Skilled Nursing and Intermediate
42 CFR 431.152 Care Facilities
AT-79-18
52 FR 32544

The Medicaid agency has established appeals procedures for skilled nursing and intermediate care facilities as specified in 42 CFR 431.153 and 431.154.

Not applicable to intermediate care facilities; such services are not provided under this plan.

TN No. 89-13
Supersedes
TN No. 80-6

Approval Date JAN 13 1989 Effective Date DEC 31 1988

HCFA ID: 1010P/0012P

Revision: HCFA-AR-80-38 (BPP)
May 22, 1980

State Maryland

Citation

4.29 Conflict of Interest Provisions

Sec. 1902(a)
(4)(C) of the Act
P.L. 95-559
Sec. 14
AT-79-42

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by Section 207 or 208 of title 18, United States Code.

SN# 81-11
supersedes

Approval Date 3/25/81 Effective Date 1-1-81

TN# —

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Maryland

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

The agency, under the authority of State law, imposes broader sanctions.

TN No. 88-9
Supersedes
TN No. 88-1

Approval Date 2/2/88

Effective Date 1/1/88

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: Maryland

Citation

1902(p) of the Act
P.L. 100-93
(secs. 7)

(b) The Medicaid agency meets the requirements of--

(1) Section 1902(p) of the Act by excluding from participation--

- (A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
- (B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that--
 - (i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
 - (ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

TN No. 88-9
Supersedes
TN No. _____

Approval Date 2/8/88

Effective Date 1/1/88

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: Maryland

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by--

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Maryland

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

TN No. 88-9
Supersedes
TN No. 87-4

Approval Date 2/8/88

Effective Date JAN 1 1988

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Maryland

Citation

1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L. 100-93
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TN No. 88-9
Supersedes 88-1
TN No. _____

Approval Date 2/8/88

Effective Date 11/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: MARYLAND

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

Total waiver

Alternative system

Partial implementation

TN No. 89-13
Supersedes
TN No. _____

Approval Date JAN 13 1989

Effective Date DEC 31 1988

HCFA ID: 1010P/0012P

Revision: HCFA-PM-90-2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: Maryland

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirement of Participation

1919 (h) (1)
and (2)
of the Act,
P.L. 100-203
(Sec. 4213 (a))

- (a) The Medicaid agency meets the requirements of section 1919 (h) (2) (A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919 (h) (2) (A) (i) through (iv) of the Act.

Not applicable to intermediate care facilities; these services are not furnished under this plan.

(b) The agency uses the following remedy(ies)

- (1) Denial of payment for new admissions.
- (2) Civil money penalty.
- (3) Appointment of temporary management.
- (4) In emergency cases, closure of the facility and/or transfer of residents

1919 (h) (2) (B) (ii)
of the Act

(c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919 (h) (2) (F)
of the Act

(d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

(1) Public recognition

(2) Incentive payments

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Maryland

Citation 4.35 Enforcement of Compliance for Nursing Facilities

42 CFR
§488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

- (1) nature of noncompliance,
- (2) which remedy is imposed,
- (3) effective date of the remedy, and
- (4) right to appeal the determination leading to the remedy.

42 CFR
§488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR
§488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR
§488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR
§488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

— The State considers additional factors. Attachment 4.35-A describes the State's other factors.

TN No. 96-4
Supersedes
TN No. _____

Approval Date: OCT 27 1995

Effective Date: JUL 01 1995

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Maryland

Citation

c) Application of Remedies

42 CFR
\$488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR
\$488.417(b)
\$1919(h)(2)(C)
of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR
\$488.414
\$1919(h)(2)(D)
of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in \$488.417 (or its approved alternative) and a State monitor as specified at \$488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR
\$488.408
1919(h)(2)(A)
of the Act.

(iv) The State follows the criteria specified at 42 CFR \$488.408(c)(2), \$488.408(d)(2), and \$488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR
\$488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR
\$488.406(b)
\$1919(h)(2)(A)
of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

- X (1) Termination
- X (2) Temporary Management
- X (3) Denial of Payment for New Admissions
- X (4) Civil Money Penalties
- X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

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JUNE 1995

State/Territory: Maryland

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) — The State uses alternative remedies.
The State has established alternative
remedies that the State will impose in
place of a remedy specified in 42 CFR
488.406(b).

- (1) Temporary Management
- (2) Denial of Payment for New Admissions
- (3) Civil Money Penalties
- (4) Transfer of Residents; Transfer of
Residents with Closure of Facility
- (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the
alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) — State Incentive Programs

- (1) Public Recognition
- (2) Incentive Payments

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

OMB No.: 0938-

State/Territory: Maryland

Citation 4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C)
and 1902(a)(53)
of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

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

HCFA ID: 7982E

State Maryland

Citation 4.37 Reimbursements for Prescribed Drugs
Section 4401 Manufacturers Rebate Agreements

The State will meet all reporting and provision of information requirements as specified in Section 1927(b)2.

The State will hold the unit rebate amount confidential and will not disclose the information for purposes other than rebate invoicing and verification.

TN# 91 - 19

Supersedes TN# _____ Approval Date 8/1/1991 Effective Date JAN 01 1991

Revision: HCFA-PM-92- 2
MARCH 1992

(HSQB)

State/Territory: MARYLAND

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| <p><u>Citation</u></p> <p>Sections 1919(b)(3) and 1919 (e)(5) of the Act</p> <p>1919(e)(5) (A) of the Act</p> <p>1919(e)(5) (B) of the Act</p> | <p>4.41 <u>Resident Assessment for Nursing Facilities</u></p> <p>(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.</p> <p>(b) The State is using:</p> <p style="padding-left: 20px;">✓ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the <u>State Operations Manual</u>) [§1919(e)(5)(A)]; or</p> <p style="padding-left: 20px;">_____ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the <u>State Medicaid Manual</u> for the Secretary's approval criteria) [§1919(e)(5)(B)].</p> |
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TN No. 93-23
Supersedes _____
TN No. _____

Approval Date APR 22 1993 Effective Date JAN 01 1993
HCFA ID: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Citation
 1902(a)(68) of
 the Act,
 P.L. 109-171
 (section 6032)

4.42 Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

- (2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

TN No. SPA 07-06
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 TN No. new

Approval Date JUN 19 2007 Effective Date: JAN. 1,
2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
- (5) The State will implement this State Plan amendment on January 1, 2007.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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Supersedes
TN No. new

Approval Date: JUN 19 2007 Effective Date: JAN. 1, 2007

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

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| <p>Citation Section 1902(a)(42)(B)(i) Of the Social Security Act</p> | <p>The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.</p> |
| | <p><input checked="" type="checkbox"/> The State is seeking an exception to establishing such program for the following reasons:</p> <p>Under the state's predominantly managed care delivery system, there is not sufficient fee-for-service claims volume to attract a RAC contractor. The State mitigates the need for the RAC contractor through the following agreements and processes:</p> <ul style="list-style-type: none"> • Managed care audits; • Maryland's Utilization Control Agent for hospital & long term care services' claims; • Maryland's Office of Inspector General's outlier claims analysis; • Maryland's Administrative Services Organization's audit requirements for mental and substance use disorder services; • The Independent Review Organization responsible for reviewing claims where medical necessity at issue; and • The Medical Integrity Program for dual-eligible beneficiaries. |
| <p>Section 1902(a)(42)(B)(ii)(I) of the Act</p> | <p>This exemption will be effective from November 1, 2024 through October 31, 2026.</p> <p><input type="checkbox"/> The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.</p> <p>Place a check mark to provide assurance of the following:</p> |
| <p>Section 1902(a)(42)(8)(ii)(II)(aa) of the Act</p> | <p><input type="checkbox"/> The State will make payments to the RAC(s) only from amounts recovered.</p> <p><input type="checkbox"/> The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.</p> <p>The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):</p> <p><input type="checkbox"/> The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.</p> <p><input type="checkbox"/> The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for ITP up to the amount equivalent to that published rate.</p> |

SECTION_4 - GENERAL PROGRAM ADMINISTRATION**4.5 Medicaid Recovery Audit Contractor Program**

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| | <p>___ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</p> |
| <p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p> | <p>___ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g, amount of flat fee, the percentage of the contingency fee):</p> |
| <p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p> | <p>___ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p> |
| <p>Section 1902 (a)(42)(I3)(ii)(IV)(aa) of the Act</p> | <p>___ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or waiver of the plan.</p> |
| <p>Section 1902 (a)(42)(I3)(ii)(IV)(bb) of the Act</p> | <p>___ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.</p> |
| <p>Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act</p> | <p>Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State. and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.</p> |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Citation

1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148
and
P.L. 111-152

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

42 CFR 455
Subpart E

PROVIDER SCREENING

X Assures that the State Medicaid agency complies with the process for screening providers under Section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

42 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS

X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

42 CFR 455.412

VERIFICATION OF PROVIDER LICENSES

X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

42 CFR 455.414

REVALIDATION OF ENROLLMENT

X Assures that providers will be revalidated regardless of provider type at least every 5 years.

42 CFR 455.416

TERMINATION OR DENIAL OF ENROLLMENT

X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

REACTIVATION OF PROVIDER ENROLLMENT

X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- 42 CFR 455.422 **APPEAL RIGHTS**
 Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.
- 42 CFR 455.432 **SITE VISITS**
 Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.
- 42 CFR 455.434 **CRIMINAL BACKGROUND CHECKS**
 Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
- 42 CFR 455.436 **FEDERAL DATABASE CHECKS**
 Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
- 42 CFR 455.440 **NATIONAL PROVIDER IDENTIFIER**
 Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- 42 CFR 455.450 **SCREENING LEVELS FOR MEDICAID PROVIDERS**
 Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
- 42 CFR 455.460 **APPLICATION FEE**
 Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.
- 42 CFR 455.470 **TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS**
 Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

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

Fee-for-Service (FFS) Interim Payments during the Change Healthcare Cybersecurity Incident

Effective retroactively to February 21, 2024, and effective for affected services provided through June 30, 2024, eligible Hospitals, Nursing Facilities, or Hospice Care Providers are eligible to receive payments for inpatient and outpatient hospital services, nursing facility services, or hospice care services in amounts representative of up to thirty days (30) of claims payments that are not otherwise paid as a result of the Change Healthcare cybersecurity incident. Eligibility for these interim payments will be limited to Hospitals, Nursing Facilities, or Hospice Care Providers who utilize Change Healthcare, and regularly bill at least \$2,000 in FFS services per month. An exception to this monthly limit and eligible providers will be granted to providers who can demonstrate that Medicaid pays a substantial majority of their revenue and was directly impacted by Change Healthcare.

The average 30-day payment is based on the total claims for inpatient and outpatient hospital services, nursing facility services, or hospice care services paid to the individual provider, inclusive of all Medicaid base payments for inpatient and outpatient hospital services, nursing facility services, or hospice care services made under the Medicaid state plan, between August 1, 2023, and October 31, 2023, divided by three (3). The payment will be made for services provided through June 30, 2024, on a monthly basis. This is not an advanced payment or prepayment prior to services furnished by providers.

These payments will be reconciled to the final payment amount the provider was eligible to receive under the Medicaid state plan for inpatient and outpatient hospital services, nursing facility services, or hospice care services during the timeframe for which it was receiving interim payments under this provision. The reconciliation will be completed within 12 months following the last day of the quarter in which the state is able to again process payments for claims following the resolution of the Change Healthcare cybersecurity incident. If the reconciliation results in discovery of an overpayment to the provider, the state will attempt to recoup the overpayment amounts within 12 months and will return the federal share within the timeframe specified in 42 CFR 433.316 and 433.320 regardless of whether the state actually recoups the overpayment amount from the provider, unless an exception applies under 42 CFR part 433, subpart F. If the reconciliation results in an underpayment to the provider, the state will make an additional payment to the provider in the amount of the underpayment within 12 months.

The state will follow all applicable program integrity requirements relating to interim payments to providers and the associated reconciliation process. The state will ensure that Hospitals, Nursing Facilities, or Hospice Care Providers receiving payments under this interim methodology for inpatient and outpatient hospital services, nursing facility services, or hospice care services will continue to furnish services to Medicaid beneficiaries during the interim payment period and that access to inpatient and outpatient hospital services, nursing facility services, or hospice care services is not limited.

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

Fee-for-Service (FFS) Interim Payments due to Extenuating Circumstances

Effective May 2, 2024, providers impacted by extenuating circumstances are eligible to receive FFS interim payments in lieu of reimbursements not otherwise paid as a result of extenuating circumstances. Extenuating circumstances include cybersecurity incidents, natural disasters, federal or state emergencies, or similar incidents that preclude providers from submitting claims to the Medicaid agency or from receiving payments from the Medicaid agency for more than 5 business days. Payments will be made in amounts representative of up to thirty days (30) of claims payments. Eligibility for these interim payments will be limited to providers that are directly impacted by the extenuating circumstances, and regularly bill at least \$2,000 in fee-for-service services per month. An exception to this monthly limit and eligible providers will be granted to providers who can demonstrate that Medicaid pays a substantial majority of their revenue, and that they were directly impacted by the extenuating circumstances.

The average 30-day payment is based on the total claims for impacted services paid to the individual impacted provider, inclusive of all Medicaid base payments for impacted services made under the Medicaid state plan, during the most recently completed quarter at least 6 months prior to the start of the extenuating circumstances, divided by three (3). This is not an advanced payment or prepayment prior to services furnished by providers.

These payments will be reconciled to the final payment amount the provider was eligible to receive under the Medicaid state plan for impacted services during the timeframe for which the provider received interim payments under this provision. The reconciliation will be completed within 12 months following the last day of the quarter in which the state is able to again process payments for claims following the resolution of the extenuating circumstances. If the reconciliation results in discovery of an overpayment to the provider, the state will attempt to recoup the overpayment amounts within 12 months and will return the federal share within the timeframe specified in 42 CFR 433.316 and 433.320 regardless of whether the state actually recoups the overpayment amount from the provider, unless an exception applies under 42 CFR part 433, subpart F. If the reconciliation results in an underpayment to the provider, the state will make an additional payment to the provider in the amount of the underpayment within 12 months.

The state will follow all applicable program integrity requirements relating to interim payments to providers and the associated reconciliation process. The state will ensure that impacted providers receiving payments under this interim methodology for impacted services will continue to furnish services to Medicaid beneficiaries during the interim payment period and that access to impacted services is not limited.