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MARYLAND DEPARTMENT OF HEALTH

Subtitle 02 DIVISION OF REIMBURSEMENTS

Chapter 01 Charges for Services Provided Through the Maryland Department of Health

Authority: Health-General Article, §§16-201—16-407, Annotated Code of Maryland

10.02.01.01

.01 Purpose.

It is the intent of this chapter that:

A. The cost of care of a recipient of services be determined in accordance with the charges for health services set under this chapter;

B. There be a single or, if appropriate, bundled charge for each health service rendered to an individual, including an individual in a group session or family group session; and

C. The methods for determining full costs be uniform among all units.

10.02.01.02

.02 Scope.

This chapter applies to:

A. All inpatient facilities operated by the Department;

B. All local health departments' programs funded by the Department;

C. All private or public alcohol and drug abuse providers funded by the Behavioral Health Administration;

D. Adult day care funded by the Office of Health Services; and

E. Family planning services funded by the Prevention and Health Promotion Administration.

10.02.01.03

.03 Definitions.

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

B. Terms Defined.

(1) "Charge" means the dollar amount set or approved by the Secretary for each clinic visit, day of care, hour, procedure, or other unit of service, as specified in the Schedule of Charges, which is the single rate to be charged all recipients of service, estates, third-party payers and insurers, or chargeable persons.

(2) "Chargeable person" means:

(a) Any responsible relative of a recipient of services;

(b) Except for a recipient of services, any other person who is legally responsible for the cost of care of the individual; and

(c) Any person who maintains a policy of health insurance under which a recipient of services is insured.

(3) "CPT" means a Current Procedural Terminology listing descriptive terms and identifying codes for reporting clinical services and procedures.

(4) "Daily per capita inpatient cost of care" means the cost of providing a day of care at a State-operated inpatient facility.

(5) "Department" means the Maryland Department of Health.

(6) "Division" means the Cost Accounting and Reimbursement Division of the Department.

(7) Federal Indirect Cost.

(a) "Federal indirect cost" means the cost the federal government recognizes as the costs of operating an inpatient facility that are not directly attributable to the operation of the inpatient facility.

(b) "Federal indirect cost" includes costs which benefit the Department as a whole and the inpatient facility indirectly, but cannot be readily identified with the inpatient facility without disproportionate effort.

(8) "Fee" means the charge or that part of the charge after an ability-to-pay determination or the elimination of disallowed costs by any third-party payer or insurer.

(9) "Health service" means any service for which a charge is established that is provided to any person, client, or resident in or by a unit of the Department, political subdivision, or grantee which is deemed appropriate by that unit to the care and treatment of an individual under its care or enrolled in its program.

(10) "Local health department" means a governmental agency that:

(a) Is funded wholly or partly by the Department;

(b) Assumes legal and financial responsibility and accountability both for funds awarded by the Department and for the provision of health services; and

(c) Operates under the general direction of a health officer who is duly appointed by and reports to the Secretary pursuant to Health-General Article, Title 3, Subtitle 3, Annotated Code of Maryland.

(11) "Medical Assistance " means the Maryland Medical Assistance Program, which is administered by the State and pays the medical bills of certain needy and low-income individuals pursuant to Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland, and 42 U.S.C. Chapter 7, Subchapter XIX.

(12) "Non-inpatient related costs" means costs at a State-operated facility which do not relate to the delivery of inpatient care.

(13) “Out-of-network services” means health services that are provided to a recipient of services which are not subject to payment at a negotiated rate under an agreement between the provider and a public or private third-party payer or insurer for the recipient of services.

(14) "Private provider" means:

(a) All private or non-local health department alcohol and drug abuse service providers funded by the Behavioral Health Administration;

(b) Adult day care service providers funded by the Office of Health Services; and

(c) Family planning service providers funded by the Prevention and Health Promotion Administration.

(15) "Provider" means a facility operated by:

(a) The Department;

(b) A local health department; or

(c) A private provider.

(16) Recipient of Services.

(a) "Recipient of services" means an individual who receives care, maintenance, treatment, or support from a facility, clinic, local health department, program, or other entity that is operated or funded wholly or partly by the Department.

(b) "Recipient of services" includes, but is not limited to an individual:

(i) In a public facility under Health-General Article, Title 10, Annotated Code of Maryland;

(ii) In a facility or Veterans' Administration hospital for comprehensive evaluation under Health-General Article, Title 7, Annotated Code of Maryland;

(iii) In a residential public facility or a facility from which this State obtains residential care under Health-General Article, Title 7, Annotated Code of Maryland; and

(iv) To whom juvenile screening or treatment services are provided under Human Services Article, §9-227(b)(1)(ii), Annotated Code of Maryland.

(17) "Responsible relative" means one or more of the following who are legally responsible for the cost of care of a recipient of services:

(a) The spouse of the recipient of services;

(b) A parent of the recipient of services who is a minor; and

(c) An adult child of the recipient of services.

(18) "Schedule of charges" means a list of charges for health services as determined pursuant to instructions provided by the Division and this chapter, and set or approved by the Secretary.

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

(20) "Shared costs" means costs arising out of shared functions between two State-operated inpatient facilities.

(21) Statewide and Departmental Overhead.

(a) "Statewide and departmental overhead" means those costs incurred by the State and allocated to the facility which benefit the State-operated inpatient facility's operation as a whole, but are not related to the delivery of direct patient care.

(b) "Statewide and departmental overhead" includes costs that are usually incurred for a common purpose benefiting the State-operated inpatient facility which are not readily identified with the State-operated inpatient facility without disproportionate effort, such as Statewide accounting, purchasing, and personnel functions.

(22) "Third-party payer disallowance" means the difference between the charge and the payment amount authorized by an agreement between a provider and a public or private third-party payer or insurer.

10.02.01.04

.04 Setting of Charges for Local Health Departments.

A. The Secretary shall approve a Schedule of Charges for each local health department containing the CPT-based charges for health services provided by the local health department which remain in effect until changed as provided in this chapter.

B. CPT-Based Charge.

(1) Each health service for which payment is sought shall be assigned an applicable CPT code.

(2) Approved Method for Determining CPT-Based Charges.

(a) The CPT-based charge for each health service shall be equivalent to 150 percent of the Medicare participating provider fee allowance for the corresponding CPT code in the most recent Medicare Physician's Fee Schedule for Maryland or the Washington, DC, suburbs, as appropriate, which is updated annually in the Federal Register by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in accordance with 42 U.S.C. §1395w-4.

(b) For any health service performed by a local health department for which a rate is not assigned in the applicable Medicare Physicians Fee Schedule, the CPT-based charge shall be equivalent to 150 percent of the Maryland Medical Assistance participating provider fee allowance for the corresponding CPT code in the Professional Services Provider Manual and Fee Schedule, as published by the Department and incorporated by reference in COMAR 10.09.02.07D.

(c) For any health service performed by a local health department for which a rate is not assigned on the applicable Medicare Physicians Fee Schedule or in the Professional Services Provider Manual and Fee Schedule, the CPT-based charge shall be equivalent to the average hourly rate of the employees providing the service to the recipients of services, calculated based upon current fiscal year salaries and fringe benefits, multiplied by the projected time of service with recipient of services, plus 20 percent for indirect costs.

C. Revisions and modifications to a Schedule of Charges shall be made and approved by the Secretary pursuant to instructions issued by the Division, provided that the Schedule of Charges for each local health department is updated and approved by the Secretary at least annually.

D. Each approved Schedule of Charges, with all revisions and modifications, shall be retained by the Division and also be prominently posted at each location of the local health department where health services are provided.

10.02.01.05

.05 Setting of Charges for State-Operated Inpatient Facilities.

A. Inpatient Charge.

(1) For each fiscal year, a daily per capita inpatient cost of care for a State-operated inpatient facility shall be determined by:

(a) Utilizing the legislatively approved budget for the inpatient facility;

(b) Adding the federal indirect cost and Statewide and departmental overhead, less shared cost, for the applicable fiscal year; and

(c) Dividing the amount determined in §A(1)(b), of this regulation, by the average daily population of the facility for the applicable fiscal year to arrive at the daily per capita inpatient cost of care for the facility.

(2) The per diem inpatient charge shall equal the daily per capita inpatient cost of care as determined in §A(1)(c) of this regulation.

(3) The per diem inpatient charge shall be set forth in the Schedule of Charges.

B. Medicare-Eligible Patient Charge.

(1) For each fiscal year, a Medicare daily per capita inpatient cost of care for a State-operated inpatient facility shall be determined by:

(a) Utilizing the legislatively approved budget for the inpatient facility, minus the cost of physician and ancillary services for the inpatient facility;

(b) Adding the federal indirect cost and Statewide and departmental overhead, less shared cost, for the applicable fiscal year; and

(c) Dividing the amount determined in §B(1)(b), of this regulation, by the average daily population of the facility for the applicable fiscal year to arrive at the Medicare daily per capita inpatient cost of care for the facility.

(2) The per diem Medicare-eligible inpatient charge shall equal the Medicare daily per capita inpatient cost of care as determined in §B(1)(c) of this regulation.

(3) The per diem Medicare-eligible inpatient charge shall be set forth in the Schedule of Charges.

C. Physician Charge.

(1) For each fiscal year, a charge of physician services provided at a Medicare-eligible State-operated inpatient facility shall be determined by utilizing the most recent Facility Medicare Physicians fee schedule for Maryland or Washington, D.C., suburbs as appropriate, which is updated annually in the Federal Register by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, pursuant to 42 U.S.C §1395w-4.

(2) The physician charge shall be set forth in the Schedule of Charges.

D. Ancillary Charge.

(1) For each fiscal year, a charge for ancillary services provided at a Medicare-eligible State-operated inpatient facility shall be determined by utilizing the most recent Facility Medicare Physicians fee schedule for Maryland or Washington, D.C., suburbs as appropriate, which is updated annually in the Federal Register by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, pursuant to 42 U.S.C §1395w-4.

(2) The ancillary charge shall be set forth in the Schedule of Charges.

E. Charges for State-operated inpatient facilities shall be based on the best estimate of costs, including all appropriate indirect costs, according to generally accepted cost accounting practice. State-operated inpatient facilities, in support of the proposed Schedule of Charges, shall report the estimate of costs in the form required by the Secretary. When the dollar amount is set by statute, the Schedule of Charges shall specify that amount.

F. Revisions and modifications to the approved Schedule of Charges to reflect changes in charges or the addition of new services shall be made when recommended by the Division and approved by the Secretary.

G. The approved Schedule of Charges, with all revisions and modifications, shall be retained in the Office of the Secretary and also be available for public inspection in the Superintendent's office of the State-operated inpatient facility.

10.02.01.06

.06 Setting of Charges for Private Providers.

A. A private provider shall submit annually, to the Division, a cost report and proposed recommended Schedule of Charges, pursuant to instructions provided by the Division.

B. At least annually, the Secretary shall approve a Schedule of Charges recommended for each private provider containing the per service charges for each private provider which remain in effect until changed as provided in this chapter.

C. Per Service Charge. A charge for each service provided shall be determined for each private provider by:

(1) Calculating the actual cost for each type of service provided;

(2) Adjusting the actual cost determined in §C(1) of this regulation for depreciation and inflation, less equipment cost; and

(3) Dividing the amount determined in §C(2) of this regulation by the actual units of service provided.

D. If a private provider's service charges are established by the Health Services Cost Review Commission (HSCRC), the requirements of §C of this regulation, do not apply.

E. A private provider's proposed service charges shall be based on the best estimate of costs, according to generally accepted cost accounting practices, including all appropriate indirect costs. Private providers, in support of their proposed Schedule of Charges shall report their estimates pursuant to instructions provided by the Division. When specific service charges are set by statute, the Secretary shall approve these service charges consistent with the statute.

F. Revisions and modifications to the approved Schedule of Charges to reflect changes in cost estimates or the addition or deletion of services for a private provider shall be made when recommended by the Division and approved by the Secretary.

G. The approved Schedule of Charges for a private provider, with all revisions and modifications, shall be retained in the Division and also be prominently posted at each location of the private provider where services are provided.

10.02.01.07

.07 Setting of Charges for Laboratories Administration.

A. The Laboratories Administration shall submit annually, to the Division, a cost report and proposed recommended Schedule of Charges, pursuant to instructions provided by the Division.

B. At least annually, the Secretary shall approve a Schedule of Charges recommended for each type of laboratory service which remains in effect until changed as provided in this chapter.

C. Charge for a Laboratory Service. A laboratory service charge shall be determined by:

(1) Calculating the total cost of a type of laboratory test which may include, but is not limited to, salary and fringe benefits of staff dedicated to the type of laboratory service, and reagents, supplies, and equipment used in the type of laboratory service;

(2) Calculating the total number of units of each type of laboratory test performed; and

(3) Dividing the total cost of a type of laboratory test, as determined in §C(1) of this regulation, by the total number of units of each laboratory service, as determined in §C(2) of this regulation.

D. Revisions and modifications to the approved Schedule of Charges for the Laboratories Administration shall be made when recommended by the Division, and approved by the Secretary, to reflect changes in cost estimates or the addition of new laboratory services.

E. The approved Schedule of Charges for the Laboratories Administration, with all revisions and modifications, shall be retained in the Office of the Secretary and also be posted prominently in the administrative offices of the Laboratories Administration.

F. Notwithstanding the procedure for determining a laboratory service charge set forth in §C of this regulation, the Secretary may adjust the Schedule of Charges if deemed to be in the best interest of public health.

10.02.01.08

.08 Determination of Ability to Pay and Fees to be Collected.

A. For inpatient care rendered in facilities operated by the Department, fees shall be established in conformity with applicable statutory requirements and regulations issued by the Secretary. The following apply:

(1) The total cost of care of each recipient of services is, in the first instance, the responsibility of the recipient of services and also the chargeable person as provided in Health-General Article, §16-102(b), Annotated Code of Maryland. Any uncollectible costs for services provided to the recipient shall become the responsibility of the State.

(2) In accordance with the provisions of Health-General Article, §16-101 et seq., Annotated Code of Maryland, recipients of services and other chargeable persons shall be jointly and severally liable for payment of inpatient charges as set forth in the Schedule of Charges adopted by the Secretary pursuant to Regulation .05 of this chapter. The Department will bill all recipients of services and chargeable persons on the basis of their available financial resources including insurance and third-party payers, up to but not exceeding the full per capita daily charge for services.

B. Outpatient and Community Based Services.

(1) For all other services, including outpatient and other community based services, the provisions of this section apply:

(2) All recipients of services and chargeable persons shall be liable for payment of the charges as set forth in the Schedule of Charges, subject to the following:

(a) For uninsured recipients of services, a waiver or reduction of charges may be granted on a case-by-case basis, following an individual determination of financial need of a recipient of services or chargeable person, based upon criteria set forth by the Secretary pursuant to §B(4) of this regulation; and

(b) For insured, in-network recipients of services, liability for payment will be reduced to account for any contractually agreed upon third-party payer disallowance.

(3) The Secretary shall issue and revise annually an ability-to-pay method and schedule for use in making an individualized determination of financial need of a recipient of services or chargeable person. The difference between the charge for the services rendered and the fee derived from this schedule shall be an ability-to-pay allowance.

(4) All local health departments and other providers shall use the uniform method of determining ability to pay as set forth by the Secretary.

(5) In those instances where only a portion of a provider's programs are subject to these regulations and a method of determining ability to pay different from that set forth by the Secretary is used, the different method may be used if approved by the Secretary.

(6) Any errors, omissions, or false statements or documents used in the determination of ability to pay or billing of any amounts due, may result in a redetermination of ability to pay and billing of any amounts due.

10.02.01.09

.09 Billing and Collection of Charges and Fees.

A. Billings and collections for care rendered in State operated inpatient facilities shall be calculated by the Department in accordance with the following procedures:

(1) The Department shall conduct a financial investigation of a recipient of services or chargeable persons' ability-to-pay in accordance with the requirements of COMAR 10.04.02.03 and COMAR 10.04.02.04;

(2) Based on the foregoing investigation, the Department shall prepare a Notice of Rate Establishment Form setting forth that portion of those charges for which the recipient of services or chargeable person shall be responsible;

(3) Upon receipt of the Notice of Rate Establishment, a recipient of services or chargeable person may, within 10 days, request the Division to conduct an informal review of the billing in accordance with COMAR 10.02.03.04, or may note an appeal from the billing in accordance with COMAR 10.02.03.05, or both.

B. The Secretary may require each local health department and other provider to submit for approval or modification a plan for billing and collection of charges, fees, and insurance benefits.

C. This plan shall set forth:

(1) The procedures to be followed in applying the ability-to-pay determination method and schedule;

(2) The methods to be used for collecting the charges, fees, and insurance benefits;

(3) The methods for receiving and accounting for all sums of money collected;

(4) The procedure to be followed in making a reasonable effort to collect unpaid amounts due; and

(5) The procedure to write off unpaid amounts due, as appropriate.

10.02.01.10

.10 Distribution and Application of Amounts Collected.

A. All payments made under the provisions of this subtitle for services rendered through facilities and programs of the Department shall be made to and collected by the Department, and shall be accounted for and deposited into the General Funds of the State Treasury by the Department.

B. Local health departments and other providers shall report all funds collected as revenues which are to be treated in accordance with Department or federal grant guidelines or other agreements and contracts under which their programs are funded.

10.02.01.11

.11 Records and Reports Required.

A. An individual financial record for each recipient of services or chargeable person shall be maintained, which shall contain relevant financial information including:

(1) The ability-to-pay determination, including, when available, applicable documents appropriate to the verification of assets, income, expenses, allowances and exemptions;

(2) The types and dates of services rendered and the approved charges, the amounts and dates of collections;

(3) An indication of the recipient of services eligibility for any federal program providing funding for the services rendered;

(4) A signed authorization to release medical information and assignment of third-party benefits;

(5) Any other information as may be required by the Secretary from time to time.

B. Financial records of fees assessed and collected shall include:

(1) Copies of prenumbered receipts;

(2) Cash receipts report;

(3) Records of deposits; and

(4) Other records necessary for proper audit trail.

C. The Secretary may waive any of the requirements of this section where appropriate upon written requests supported by reasons and justifications.

10.02.01.9999

Administrative History

Effective date: January 6, 1976 (3:4 Md. R. 215)

Promulgated as emergency provision April 14, 1976 (3:11 Md. R. 586)

Regulations .01—.07 amended effective July 21, 1976 (3:15 Md. R. 791)

Regulation .02 amended effective May 5, 1986 (13:9 Md. R. 1027)

Regulation .04 amended as an emergency provision effective March 18, 1985 (12:7 Md. R. 693); adopted permanently effective June 3, 1985 (12:11 Md. R. 1047)

Regulation .04 amended as an emergency provision effective November 14, 1985 (12:25 Md. R. 2468); adopted permanently effective April 6, 1986 (13:7 Md. R. 795)

Regulation .04 amended effective May 5, 1986 (13:9 Md. R. 1027)

Regulation .04A amended effective March 23, 1987 (14:6 Md. R. 714); June 27, 1988 (15:13 Md. R. 1552); April 1, 1991 (18:6 Md. R. 685)

Regulations .05A and .07A amended effective May 5, 1986 (13:9 Md. R. 1027)

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Chapter revised as an emergency provision effective July 1, 1995 (22:15 Md. R. 1112); revised permanently effective October 9, 1995 (22:20 Md. R. 1543)

Regulation .03 amended as an emergency provision effective June 29, 1996 (23:15 Md. R. 1080); amended permanently effective November 4, 1996 (23:22 Md. R. 1496)

Regulation .03D amended as an emergency provision effective November 14, 1997 (24:25 Md. R. 1717); amended permanently effective February 23, 1998 (25:4 Md. R. 243)

Regulation .03D amended as an emergency provision effective September 14, 1998 (25:21 Md. R. 1571); amended permanently effective December 28, 1998 (25:26 Md. R. 1923)

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Chapter revised as an emergency provision effective December 1, 2000 (27:25 Md. R. 2277); revised permanently effective March 19, 2001 (28:05 Md. R. 551)

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Chapter revised effective August 17, 2015 (42:15 Md. R. 1055)

Regulation .04B amended effective February 27, 2017 (44:4 Md. R. 252)