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ATTACHMENT 4.19 - C

The Program will reimburse the cost for reserving beds for recipients in skilled and intermediate care facilities at the appropriate rate, less recipient's available resource, for: 1) therapeutic home visits for a period not to exceed a total of 18 days during any calendar year; 2) hospitalization for an acute condition for a maximum of 15 days per single hospital stay.

A. Therapeutic Home Visits

Therapeutic home visits must be provided for in the patient's plan of care and the attending physician must complete an authorization form not more than 30 days prior to the patient's anticipated leave of absence.

B. Leave for Hospitalization

Reimbursement for reserving beds for hospitalization is subject to the following:

1. The hospital leave is reasonably expected to be 15 days or less;
2. The Utilization Control Agent certifies that any days spent in the hospital are medically necessary;
3. The provider guarantees that the recipient's bed will be available upon return from the hospital stay if the recipient is discharged from the hospital within 16 days;
4. The provider submits a hospital leave form designated by the Department with the invoice covering the month in which the hospital discharge occurred;
5. No payment is made for days after the date of death if the recipient dies during the hospital stay.

State of Maryland

OFFICE OF THE SECRETARY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Harry Hughes, Governor

Adele Wilzack, R.N., M.S., Secretary

December 27, 1984

Mr. Everett Bryant
Regional Administrator
Division of Program Operations
Health Care Financing Administration
P.O. Box 7760, 3535 Market Street
Philadelphia, Pennsylvania 19101

JAN
DIVISION OF PROGRAM OPERATIONS

Dear Mr. Bryant:

Interim State Medicaid Manual Instructions 84-1 (Section 6007) provided specific instructions to each state concerning requirements of Public Law 98-369 (The Deficit Reduction Act of 1984). This letter includes the assurances which must be submitted by December 31, 1984.

Skilled Nursing Facilities/Intermediate Care Facilities

The methodology for reimbursing skilled nursing facilities and intermediate care facilities under the Maryland Medical Assistance Program is specified in Attachment 4.19(d) of the State Plan. A method other than the Medicare methodology is used for determining allowable captial-related payments.

Capital-related payments under the Maryland methodology are based on the current replacement value of the facility. Because replacement cost and not market value is used as the basis for capital-related payments, the value of the facility, for reimbursement purposes, does not change when sold. Therefore, capital-related payments will not change solely because of a change in ownership.

Maryland therefore submits this assurance and can demonstrate that the payment methodology used for payment of skilled nursing facilities and intermediate care facilities under Medical Assistance beginning January 1, 1983, can reasonably be expected not to increase payments solely as a result of change of ownership in excess of the increase which would result from applying 1861(v)(1)(O) of the Act, as applied to owners of record on July 18, 1984.

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Baltimore Area 383-7555
D.C. Metro Area 565-0451

Hospitals

A. Hospitals Not Participating in the Medicare Experiment.

For these hospitals, the State Plan cites the Medicare principles for determining reimbursement, including allowable capital-related cost. For these hospitals, Maryland will continue with the Medicare methodology and makes the assurance that it will not exceed the Medicare Statute A 1861(v)(1)(O).

B. Hospitals Participating in the Medicare Experiment.

As the Medicare Experiment is a waiver of Medicare reimbursement principles, my staff has been advised by the Central Office that no assurances are required.

I trust that the information presented meets the requirements specified in Section 6007 of the State Medicaid Manual. If you have any questions or need any additional information, please call Mr. Douglas H. Morgan, Assistant Secretary for Medical Care Programs, at (301)383-6327.

Sincerely,

Adele Wilzack, R.N., M.S.
Secretary

AW:lcd

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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4.19(d) Nursing facility payment rates, based on Code of Maryland Regulations (COMAR) 10.09.10, account for the cost of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid benefits.

Payment rates for nursing facilities are based on a prospective reimbursement methodology.

Payment rates for nursing facilities are based on pricing and are the sum of per diem reimbursement calculations in four cost centers: administrative/routine, other patient care, capital, and nursing services (which include certain direct care costs such as therapies). Prospective payments are considered paid in full.

Additional allowable ancillary payments are listed and are paid prospectively and in full.

In accordance with the Omnibus Budget Reconciliation Act of 1987, nursing facility payment rates, effective October 1, 1990, take into account the costs of nursing facilities' compliance with the requirements of Sections 1919(b) (other than paragraph (3)(F)), 1919(c), and 1919(d) of the Social Security Act.

Aggregate payments for these facilities may not exceed Medicare upper payment limits as specified at 42 CFR 447.272.

A provider that renders care to Maryland Medicaid participants of less than 1,000 days of care during the provider's fiscal year may choose to not be subject to cost reporting requirements and to accept as payment the Medicaid statewide average payment for each day of care.

Nursing facilities that are owned and operated by the State are not paid in accordance with these provisions. These facilities are reimbursed reasonable costs based upon Medicare principles of reasonable cost as described at 42 CFR 413.

Unless otherwise defined, indexing noted under the Prospective Reimbursement Methodology refer to the latest Skilled Nursing Home without Capital Market Basket Index, two (2) months before the period for which rates are being calculated.

Effective July 1, 2023, provider payment rates shall be increased by four (4) percent from the methodology described herein.

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Prospective Reimbursement Methodology

The State initially established prices for each cost center for the rate period January 1, 2015, through June 30, 2015, and rebases prices between every two and four rate years. Prices may be rebased more frequently if the State determines that there is an error in the data or in the calculation that results in a substantial difference in payment, or if a significant change in provider behavior or costs has resulted in payment that is inequitable across providers. In years in which prices are not rebased, prices are subject to annual indexing.

Administrative/Routine Costs

The Administrative/Routine cost center includes the following expenses: administrative, medical records, training, dietary, laundry, housekeeping, operation and maintenance, and capitalized organization and start-up costs. There are 4 reimbursement groups in this cost center based on geographic location, as specified under COMAR 10.09.10.30.

The State establishes a price for each reimbursement group. The price is the median cost per diem of all facilities in the group multiplied by 1.025. The price is based on the most recent Nursing Home Uniform Cost Report submitted by each nursing facility, indexed by the market basket, divided by the greater of total resident days or days at full occupancy times an occupancy standard calculated as the statewide average occupancy, not including providers with occupancy waivers, plus 1.5 percent.

Providers that maintain kosher kitchens and have administrative and routine costs in excess of the price that are attributable to dietary expense, shall receive an add-on to its per diem payments in an amount up to 15 percent of the median per diem cost for dietary expense in its reimbursement group.

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Other Patient Care Costs

The Other Patient Care cost center includes expenses for providing: a medical director, pharmacy, recreational activities, patient care consultant services, raw food, social services and religious services. There are 4 reimbursement groups in this cost center, based on geographic location, as specified under COMAR 10.09.10.30.

The State establishes a price for each group. The price is the median cost per diem of all facilities in the group multiplied by 1.07. The price is based on the most recent indexed Nursing Home Uniform Cost Report submitted by each nursing facility divided by the total resident days.

Providers that maintain kosher kitchens and have other patient care costs in excess of the price that are attributable to raw food expense, shall receive an add-on to its per diem payments in an amount up to 15 percent of the median per diem cost for raw food expense in its reimbursement group.

Capital Costs

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

At least every 4 years, each facility's building(s), nonmovable equipment and land are appraised. A fair rental value is calculated when the per bed cost appraisal, with a maximum of $120,000, is calculated and then multiplied by a geographic-specific amount (10 percent in Baltimore City, 8 percent in all other jurisdictions). The fair rental value is then divided by the greater of total resident days or days at full occupancy times an occupancy standard calculated as the statewide average occupancy, not including providers with occupancy waivers, plus 1.5 percent.

Two months prior to the start of a rate year, each facility's real estate taxes are divided by the greater of total resident days or days at full occupancy times an occupancy standard calculated as the statewide average occupancy, not including providers with occupancy waivers, plus 1.5 percent.

The per diem rate is the sum of the fair rental value and real estate tax calculations above.

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Nursing Services Costs

The Nursing Services cost center includes costs related to the direct provision of nursing services to residents. Initially, the State sets a Nursing Services price for each of four groups based on geographic location as specified under COMAR 10.09.10.30. The State sets the price based on the following steps:

(1) Each cost report's indexed Nursing Service costs is divided by the actual days of nursing care to arrive at the indexed Nursing Service cost per diem.
(2) The indexed Nursing Service cost per diem is normalized to the statewide average case mix index by multiplying the indexed Nursing Service cost per diem by the facility's normalization ratio calculated as the statewide average case mix index divided by the total facility case mix index.
(3) For each reimbursement group, each cost report's Medicaid resident days is used in the array of cost per diems in the previous step to calculate the Medicaid day weighted median.
(4) The final price for Nursing Service costs for each reimbursement group is calculated as the geographic regional Medicaid day weighted median Nursing Service cost multiplied by 1.0825.

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

(5) Determine the Nursing Service price for the facility's geographic region;
(6) Calculate an initial nursing facility rate by multiplying the price by the facility average Medicaid case mix index divided by the statewide average case mix index;
(7) Calculate a Medicaid adjusted Nursing Service cost per diem by multiplying the per diem identified under step (1) by the Medicaid case mix adjustment ratio calculated as the facility average Medicaid case mix index divided by the total facility case mix index; and
(8) Calculate the final Nursing Service rate as the initial nursing facility rate reduced by any amount by which the Medicaid adjusted cost per diem is less than 95 percent of the initial nursing facility rate.

Facility-specific case mix is adjusted quarterly based on submitted, and reviewed, Minimum Data Set 3.0 from each facility. Case mix from the quarter before the immediate prior quarter is used to set the per diem for each rate quarter.

Facilities that are authorized to provide ventilator services utilize the above pricing methodology, however receive a payment for ventilator days of care using a facility average Medicaid case mix that includes only residents receiving ventilator care plus $285. The payment for ventilator services is prospective and paid in full.

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Reimbursement of Allowable Ancillary Services

The payment for allowable ancillary services is prospective and paid in full. Prospective reimbursement for specialized support surfaces for pressure ulcer care is determined as follows:

(1) A Class A Support Surface is a mattress replacement which, has been approved as a Group 2 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Medical Equipment Regional Carrier. A Class A Support Surface will be reimbursed per day at the Medicare Durable Medical Equipment Regional Carrier Maryland monthly fee cap, in effect at the beginning of the State fiscal year, for HCPCS Code E0277 multiplied by 12 and then divided by the number of days in the State fiscal year.

(2) A Class B Support Surface is an air fluidized bed which has been approved as a Group 3 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Medical Equipment Regional Carrier. A Class B Support Surface will be reimbursed per day at the Medicare Durable Medical Equipment Regional Carrier Maryland monthly fee cap in effect at the beginning of the State fiscal year, for HCPCS Code EO194 multiplied by 12 and then divided by the number of days in the State fiscal year.

Power wheelchairs are covered under preauthorization by the State at a prospective rate with payment in accordance with Maryland regulations for medical supplies and equipment at COMAR 10.09.12.

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

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Pay-for-Performance

Maryland nursing facilities are eligible to participate in a pay-for-performance program if they have 45 or more licensed nursing facility beds, are not a continuing care retirement community, and have not been, during the 1-year period ending March 31, denied payment for new admissions, identified as delivering substandard quality of care, or identified as a Special Focus facility.

Providers shall be scored and ranked based on the following criteria:

(1) Staffing levels

In order to evaluate and compare staffing, the Program will use data from the Payroll Based Journal to calculate average hours of care per resident per day. Using a 4.13 hours standard for a facility with an average resident acuity, the Program sets an acuity-adjusted goal for each provider based on its resident mix. Providers are scored on their actual staffing relative to their facility-specific goal. Providers that meet or exceed their goal shall be scored at 100 percent.

Staffing levels will comprise of 20 percent of the overall score

(2) Staff Stability

Continuity and stability of nursing staff will be measured by the percent of nursing staff who have been employed by the facility for 2 years or longer. Nursing facilities will be required to submit a listing of their staff who were employed during the pay period that includes March 31, including their dates of hire.

Staff stability will comprise 15 percent of the overall score.

(3) Family satisfaction

Family satisfaction is based on results from the facility's most recent Nursing Facility Family Survey conducted by the Maryland Health Care Commission. Providers are scored on questions regarding general satisfaction (12%) and on several categories of questions regarding specific aspects of care and environment in the facility (18%). These questions will comprise 30 percent of the overall score.

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(3) Minimum Data Set Quality Indicators

Providers shall receive scores for the 3-month period ending December 31 of the most recent prior State fiscal year based on the following quality indicators for long-stay residents from the Minimum Data Set published by the Centers for Medicare & Medicaid Services. These scores will comprise 30 percent of the overall score.

-Percent of High-Risk Residents Who Have Pressure Sores
-Percent of Residents With Falls Resulting in Major Injury
-Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
-Percent of Residents with a Urinary Tract Infection
-Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season
-Percent of Long-Stay Residents Who Were Assessed and given Pneumococcal Vaccination

(4) Staff immunizations

Providers shall receive 5 points if 95 percent or more of the nursing facility's staff, which includes all staff classifications, have been vaccinated against seasonal influenza. Alternatively, providers shall receive 2 points if at least 90 but less than 95 percent of the nursing facility's staff have been vaccinated against seasonal influenza. This score will comprise 5 percent of the overall score.

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Eligible facilities shall receive scores for staffing levels and staff stability, family satisfaction, and clinical quality indicators based on the following methodology:

- The highest ranked facility receives 100 percent of the points available;
- The average score, weighted by total days of care, receives 50 percent of the points available;
- Zero points would be received by and facility whose raw score is below the mean by an amount equal to or greater than the difference between the highest score and the mean score; and
- All other facilities will receive points proportionate to where the score falls within the range between the highest and zero.

  Facilities will receive an overall score comprised of the sum of the points awarded for each quality measure.

  Payments will be distributed annually.

During State Fiscal Year 2011, July 1, 2010 through June 30, 2011, 0.2445 percent of budge allocation for nursing facility services shall be distributed based on pay-for-performance scores. Beginning in the State Fiscal Year 2012, July 1, 2011 through June 30, 2020, 0.5 percent of the budget for nursing facility services shall be distributed based on pay-for-performance scores. Effective State Fiscal Year 2021, July 1, 2020, and each year thereafter, one percent of the budget for nursing facility services shall be distributed based on pay-for-performance scores. Eighty-five percent of the funds shall be distributed to the highest scoring facilities, representing 40 percent of the eligible days of care, such that the highest scoring facility receiving payment shall receive twice the amount per Medicaid day of care as the lowest-scoring facility receiving payment.

Fifteen percent of the pay-for-performance funds shall distributed to eligible facilities that did not score among the highest 40 percent of the eligible days of care, but whose scores represented an improvement compared with the prior state fiscal year. Facilities shall be ranked according to the greatest point increase compared with the prior fiscal year, and funds shall be distributed such that the facility with the greatest point increase shall receive twice the amount per Medicaid day of care as the facility with the smallest point increase.

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Intermediate Care Facilities for Individuals with Intellectual Disabilities are a separate class and such facilities are reimbursed reasonable costs. The determination of reasonable costs is based on Medicare principles of reasonable cost as described at 42 CFR 413. An average cost per day for provider-based physician services is developed and paid in accordance with retrospective cost reimbursement principles. Payment in the aggregate may not exceed Medicare upper limits as specified at 42 CFR 447.272.

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Appendix A
COMAR 10.09.10.30

.30 Reimbursement Classes.

A. The reimbursement classes for the Administrative and Routine cost center are as follows:

(1) Facilities in the Baltimore metropolitan region consisting of the following counties:

(a) Anne Arundel,
(b) Baltimore,
(c) Carroll,
(d) Harford, and
(e) Howard;

(1-1) Facilities in Baltimore City;

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

(a) Charles,
(b) Montgomery, and
(c) Prince George's;

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

(a) Allegany,
(b) Calvert,
(c) Caroline,
(d) Cecil,
(e) Dorchester,
(f) Frederick,
(g) Garrett,
(h) Kent,
(i) Queen Anne's,
(j) St. Mary's,
(k) Somerset,
(l) Talbot,
(m) Washington,
(n) Wicomico, and
(o) Worcester.

B. The reimbursement classes for the Other Patient Care cost center are based on the county groupings as specified in §A of this regulation.

C. The reimbursement classes for the Nursing Service cost center are as follows:

(1) Facilities in the Baltimore region consisting of Baltimore City and Baltimore County;

(2) Facilities in the Central Maryland region consisting of the following counties:
(a) Anne Arundel,
(b) Carroll, and
(c) Howard;

(3) Facilities in the Washington region consisting of the following counties:
(a) Charles,
(b) Frederick,
(c) Montgomery, and
(d) Prince George's;

(4) Facilities in the nonmetropolitan region consisting of the following counties:
(a) Calvert,
(b) Caroline,
(c) Cecil,
(d) Dorchester,
(e) Harford,
(f) Kent,
(g) Queen Anne's,
(h) St. Mary's,
(i) Somerset,
(j) Talbot,
(k) Wicomico, and
(l) Worcester;

(5) Facilities in the Western Maryland region consisting of the following counties:
(a) Allegany,
(b) Garrett, and
(c) Washington.

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

(1) Facilities in the Baltimore Metro region consisting of Baltimore City and the following counties:
(a) Anne Arundel;
(b) Baltimore;
(c) Carroll;
(d) Cecil;
(e) Harford; and
(f) Howard;

(2) Facilities in the Washington Metro region consisting of the following counties:
(a) Calvert;
(b) Charles;
(c) Frederick;
(d) Montgomery;
(e) Prince George's; and
(f) St. Mary's;

(3) Facilities in the Eastern region consisting of the following counties:
(a) Caroline;
(b) Dorchester;
(c) Kent;
(d) Queen Anne's;
(e) Somerset;
(f) Talbot;
(g) Wicomico; and
(h) Worcester; and

(4) Facilities in the Western region consisting of the following counties:
(a) Allegany;
(b) Garrett; and
(c) Washington.

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

STATE OF MARYLAND

TIMELY CLAIMS PAYMENT

Definition of Claim

A claim is an invoice for services rendered to a recipient who is receiving benefits through the Medical Assistance Program:

UB-04 Form:

Institutional inpatient services for Acute Care General, Long Term Care, Hospice, Chronic, Psychiatric and Rehabilitative Facilities all inclusive of Room and Board plus ancillary charges.

Institutional outpatient services all inclusive of ancillary charges for a specific date of service.

Home Health and Dialysis services- all inclusive for services rendered within the same month for each date of service charged/billed.

CMS-1500:

Line item billing for Professional services rendered on a specific date of service.

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(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:

A. Health Insurance Information

Applications for assistance filed with local departments of social services:

1. All applicants for Public Assistance and Medical Assistance, with the exception of applicants for Supplemental Security Income, report health insurance information at each application and redetermination of eligibility.

2. All application forms contain questions about health insurance.

3. Information is conveyed daily to the Division of Medical Assistance Recoveries on the Insurance Reporting Form prepared by the eligibility technician in the local department of social services during the eligibility interview and/or from the written application form.

   a. Information includes known or potential health insurance, employment and union affiliation.

   b. Information is requested for the applicant and absent parent(s), as appropriate.

   c. The Insurance Reporting Form is used for both Public Assistance and Medical Assistance cases.

Applications for Supplemental Security Income filed with the Social Security Administration (1634 agreement):

1. All applicants for Supplemental Security Income report health insurance information at application.

2. Maryland has an agreement in place with the Social Security Administration for that agency to gather health insurance lead information and forward the information monthly to the Division of Medical Assistance Recoveries.

Automated data match with Blue Cross and Blue Shield of Maryland:

Quarterly match of Medical Assistance recipient file with Blue Cross and Blue Shield subscriber and dependent files.

B. SWICA and SSA Wage and Earnings files

Information is available daily to the local departments of social services through IEVS. Eligibility technicians check the IEVS system for information on the absent parent's employment and refer the absent parent to the local IV-D unit for further investigation. The IV-D unit refers potential health insurance resources to the Division of Medical Assistance Recoveries for validation.

C. State IV-A Agency

Information is obtained daily by the eligibility technicians in the local departments of social services at time of application and redetermination. The technicians refer potential health insurance resources to the Division of Medical Assistance Recoveries for validation.

D. State Worker's Compensation Commission

1. The State Worker's Compensation Commission provided an initial display of its full automated file.

2. The Commission sends a quarterly list of accretions to the file to the Division of Medicaid Information Systems.

E. State Motor Vehicle Accident Report Files

The Department of Health and Mental Hygiene attempted to get an agreement with the Division of Motor Vehicles to conduct data matches at no cost to the Medicaid Program. The Division of Motor Vehicles has instituted a 2 and 1/2 cent charge for each record and would make no exception for the Medicaid Program. The TPL Program did not think this was cost effective because the matches have identified no

cases which have not been identified by other sources. The cost of the match to the Program would be approximately $20,000 a year; therefore, the cost of the match is not considered to be cost effective.

F. Diagnosis and Trauma Code Edits

The Medicaid Management Information System produces a monthly list of payments made for Medicaid recipients that contain certain diagnosis codes from 800 through 999 (ICDCM, International Classification of Disease). The Health Care Financing Administration (HCFA) has approved a diagnosis and trauma code waiver for certain codes. These codes are on file at the State Agency and also at the HCFA Region III office.

(2) Describes the methods the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i):

Applications for assistance filed with local departments of social services and applications for Supplemental Security Income filed with the Social Security Administration

A. Validation Process

1. Blue Cross and Blue Shield of Maryland - quarterly data match.

2. Other health insurance carriers - written inquiry (validation form) mailed to carrier.

B. Incorporation of validated information

1. Blue Cross and Blue Shield of Maryland

Data match response is processed by the Division of Medicaid Information Systems and automatically updates the Master Eligibility File and the Third Party Liability and Benefit Recovery Subsystem and generates a printout to the Division of Medical Assistance Recoveries for creation of a hardcopy case file.

2. Other carriers

a. Information on returned validation form is converted to keychart for entry by the Division of Medical Assistance Recoveries' personnel on the master eligibility file and the Third Party Liability and Benefit Recovery Subsystem.

b. Hardcopy case file is created with referral form, validation form and proofed keychart.

C. Timeframe for incorporation

1. All validated information is incorporated within 30 days of receipt.

2. The Division of Medicaid Information Systems-entered information: timeliness of entry is validated by run dates of data match and systems update.

3. The Division of Medical Assistance Recoveries-entered information: timeliness of entry is validated by the system-generated data entry date on the Third Party Liability and Benefit Recovery Subsystem when entry is keyed.

D. System for tracking timeliness of follow-up

1. All carriers: Lead information is dated on receipt.

2. All carriers except Blue Cross and Blue Shield of Maryland

a. Manually prepared inquiry letters are tickled for follow-up action. Inquiries are coded with julian dates for pulling and sending follow-up requests.

b. Returned validation forms with health insurance information are date-stamped and matched with referral forms for case file creation and keycharting.

c. Systems-generated data entry date is entered on Third Party Liability and Benefit Recovery Subsystem when data are keyed.

3. Blue Cross and Blue Shield of Maryland - validated by run dates of data match and systems update.

SWICA and SSA Wage and Earnings files

A. Identification

1. Information is checked against Third Party Liability and Benefit Recovery Subsystem to eliminate exact duplicates.

2. Validation process for unduplicated information

a. Telephonic or written inquiry to recipient, absent parent or employer, if appropriate, to identify carrier.

b. Blue Cross and Blue Shield of Maryland - quarterly data match will validate coverage.

c. Other carrier - written inquiry (validation form) is mailed to carrier.

B. Incorporation of validated information

1. Blue Cross and Blue Shield of Maryland

Data match response is processed by the Division of Medicaid Information Systems and automatically updates the Master Eligibility File and the Third Party Liability and Benefit Recovery Subsystem and generates a printout to the Division of Medical Assistance Recoveries for creation of a hardcopy case file.

2. Other carriers

a. Information on returned validation form is converted to keychart for entry by the Division of Medical Assistance Recoveries' personnel on the Master Eligibility File and the Third Party Liability and Benefit Recovery Subsystem.

b. Hardcopy case file is created with referral form, validation form and proofed keychart.

C. Timeframe for incorporation

1. All validated information is incorporated within 30 days of receipt.

2. The Division of Medicaid Information Systems-entered information: timeliness of entry is validated by run dates of data match and systems update.

3. The Division of Medical Assistance Recoveries-entered information: timeliness of entry is validated by the system-generated data entry date on the Third Party Liability and Benefit Recovery Subsystem when entry is keyed.

D. System for tracking timeliness of follow-up

1. Dates of telephonic inquiries are documented on case action summaries.

2. Manually-prepared inquiry letters are tickled for follow-up inquiries.

3. Returned inquiry letters with third party lead information are date-stamped and matched with inquiry letters for issuance of validation forms to health insurance carrier.

4. All carriers: Lead information is dated on receipt.

5. All carriers except Blue Cross and Blue Shield of Maryland

a. Manually prepared inquiry letters are tickled for follow-up action. Inquiries are coded with julian dates for pulling and sending follow-up requests.

b. Returned validation forms with health insurance information are date-stamped and matched with referral forms for case file creation and keycharting.

c. Systems-generated data entry date is entered on Third Party Liability and Benefit Recovery Subsystem when data are keyed.

6. Blue Cross and Blue Shield of Maryland - validated by run dates of data match and systems update.

State IV - A Agency

A. Identification

1. Information is checked against Third Party Liability and Benefit Recovery Subsystem to eliminate exact duplicates.

2. Validation process for unduplicated information

a. Telephonic or written inquiry to recipient, absent parent or employer, if appropriate, to identify carrier.

b. Blue Cross and Blue Shield of Maryland - quarterly data match will validate coverage.

c. Other carrier - written inquiry (validation form) is mailed to carrier.

B. Incorporation of validated information

1. Blue Cross and Blue Shield of Maryland

Data match response is processed by the Division of Medicaid Information Systems and automatically updates the Master Eligibility File and the Third Party Liability and Benefit Recovery Subsystem and generates a printout to the Division of Medical Assistance Recoveries for creation of a hardcopy case file.

2. Other carriers

a. Information on returned validation form is converted to keychart for entry by the Division

of Medical Assistance Recoveries' personnel on the master eligibility file and the Third Party Liability and Benefit Recovery Subsystem.

b. Hardcopy case file is created with referral form, validation form and proofed keychart.

C. Timeframe for incorporation

1. All validated information is incorporated within 30 days of receipt.

2. The Division of Medicaid Information Systems-entered information: timeliness of entry is validated by run dates of data match and systems update.

3. The Division of Medical Assistance Recoveries-entered information: timeliness of entry is validated by the system-generated data entry date on the Third Party Liability and Benefit Recovery Subsystem when entry is keyed.

D. System for tracking timeliness of follow-up

1. Dates of telephonic inquiries are documented on case action summaries.

2. Manually-prepared inquiry letters are tickled for follow-up action.

3. Returned inquiry letters with third party lead information are date-stamped and matched with inquiry letters for issuance of validation forms to health insurance carrier.

4. All carriers: Lead information is dated on receipt.

5. All carriers except Blue Cross and Blue Shield of Maryland

a. Manually prepared inquiry letters are tickled for follow-up action. Inquiries are coded with julian dates for pulling and sending follow-up requests.

b. Returned validation forms with health insurance information are date-stamped and matched with referral forms for case file creation and

keycharting.

c. Systems-generated data entry date is entered on Third Party Liability and Benefit Recovery Subsystem when data are keyed.

6. Blue Cross and Blue Shield of Maryland - validated by run dates of data match and systems update.

State Workers Compensation Commission

A. Identification

1. State Worker's Compensation Commission file is run against the Medicaid Master Eligibility File for matches by Social Security Number.

2. All matches are checked against the Third Party Liability and Benefit Recovery Subsystem to eliminate exact duplicates.

3. A dated printout containing all unduplicated entries is sent to the Division of Medical Assistance Recoveries for follow-up inquiries to recipient and employer to verify legal liability.

B. Incorporation of validated information

1. A keychart is prepared and data are entered by the Division of Medical Assistance Recoveries' personnel on the Master Eligibility File and the automated Third Party Liability and Benefit Recovery Subsystem.

2. A hardcopy case file is created with correspondence, medical payments and proofed keychart.

C. Timeframe for incorporation

1. All validated information is incorporated within 30 days of receipt.

2. Timeliness of data entry is validated by the system-generated data entry date on the Third Party Liability and Benefit Recovery Subsystem when the entry is keyed.

D. System for tracking timeliness of follow-up

1. Lead information from Worker's Compensation Commission records is processed for match against the Master Eligibility File and the Third Party Liability and Benefit Recovery Subsystem by the Division of Medicaid Information Systems. After the file match is completed, a dated printout of unduplicated entries is provided to the Division of Medical Assistance Recoveries.

2. Manually-prepared inquiry letters are tickled for follow-up action.

3. Returned inquiry letters with third party information are date-stamped and matched with inquiry letters for case file creation and key-charting.

4. A system-generated data entry date is entered on the Third Party Liability and Benefit Recovery Subsystem when data are keyed.

(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:

N/A

the Master Eligibility File and the automated Third Party Liability and Benefit Recovery Subsystem.

2. A hardcopy case file is created with correspondence, medical payments and proofed keychart.

C. Timeframe for incorporation

1. All validated information is incorporated within 30 days of receipt.

2. Timeliness of data entry is validated by the system-generated data entry date on the Third Party Liability and Benefit Recovery Subsystem when the entry is keyed.

D. System for tracking timeliness of follow-up

1. Lead information from Maryland Department of Transportation, Motor Vehicle Administration, is processed for match against the Master Eligibility File and the Third Party Liability and Benefit Recovery Subsystem by the Division of Medicaid Information Systems. After the file match is completed, a dated printout of unduplicated entries is provided to the Division of Medical Assistance Recoveries.

2. Manually prepared inquiry letters are tickled for follow-up action.

3. Returned inquiry letters with third party information are date-stamped and matched with inquiry letters for case file creation and key-charting.

4. A system-generated data entry date is entered on the Third Party Liability and Benefit Recovery Subsystem when data are keyed.

(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.

A. Identification

1. The Medicaid Management Information System produces an inquiry letter to the recipient requesting information on liable third parties. Letters are produced only for recipients with diagnosis codes which have not been waived pursuant to 4.22-A(1)F who are not already identified as having an outstanding trauma code-based inquiry or a known trauma code-based liable third party, as recorded in the Third Party Liability and Benefit Recovery Subsystem.

B. Incorporation of validated information

1. A keychart is prepared and data are entered by the Division of Medical Assistance Recoveries' personnel on the Master Eligibility File and the automated Third Party Liability and Benefit Recovery Subsystem.

2. A hardcopy case file is created with correspondence, medical payments and proofed keychart.

C. Timeframe for incorporation

1. All validated information is incorporated within 30 days of receipt.

2. Timeliness of data entry is validated by the system-generated data entry date on the Third Party Liability and Benefit Recovery Subsystem when the entry is keyed.

D. System for tracking timeliness of follow-up

1. System-generated inquiry letters are tickled for manual follow-up action.

2. Returned inquiry letters with third party information are date-stamped and matched with inquiry letters for case file creation and key-charting.

3. A system-generated data entry date is entered on the Third Party Liability and Benefit Recovery Subsystem when data are keyed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

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

Requirements for Third Party Liability - Payment of Claims

(1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

(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.

(a) Claims submitted by providers for all services except pharmacy, preventive pediatric care, including EPSDT services and routine prenatal services, will be cost-avoided when the Program has established the probable existence of third party liability.

(b) Providers are not 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.

(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 reimbursement.

(a) Reimbursement from estates, tort liabilities, workmen's compensation and paternity cases will not be sought for claims of less than $100.

(b) Full reimbursement will be sought of all court ordered restitutions, i.e., assault convictions or other directed repayments.

(c) Health insurance claims not cost-avoided will be pursued through post-payment recovery. Reimbursement will not be sought for claims less than $25, except pharmacy claims billable to Blue Cross and Blue Shield of Maryland under the cost avoidance waiver.

(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.

The Medical Assistance Program has regulations for each service type establishing proper billing practices for all enrolled providers. These regulations include the requirement to refund the lesser of the TPL or Program payment when both are received for the same service. Providers agree to abide by these regulations when they sign a provider agreement.

The Provider enrollment and Provider relations units of Medical Care Operations Administration communicate with and educate providers in the proper application of Program regulations on a daily basis, through provision of written materials and on-site assistance, if necessary.

The Program investigates all recipient complaints of excessive provider billing and resolves the problem through provider education and assistance or, if warranted, referral for investigation and possible prosecution.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

N/A

State/Territory: MARYLAND

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State Plan Under Title XIX Of The Social Security Act

State: Maryland

INCOME AND ELIGIBILITY VERIFICATION SYSTEM

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. **(Section 1137 of the Act and 42 CFR 435.940 through 435.960)**

(c) 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.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

State Plan Under Title XIX Of The Social Security Act

State: Maryland

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

A description of the system used by Maryland State Agency is listed below:

Maryland has been a member of the PARIS Project every quarter since August 1999. Using the Social Security Number of recipients as the key, the match process compares benefit payouts made by States for TANF (TCA), SNAP (known in Maryland as Food Supplement Program (FSP) and MA against various databases. There are three parts of the PARIS data match process. The Veterans Administration (VA) database match determines if an individual is collecting VA benefits. The Interstate match compares participating States data against each other and determines if an individual is collecting benefits in more than one State. The Federal match determines whether anyone receiving benefits is also collecting a salary or retirement pension as a current or former U.S. military or civil service employee.

The federal PARIS computer facility performs the data match and provides any hits to the State. State staff verify the data and follow appropriate verification procedures and adverse action. The Family Investment Administration has added three new Alert screens in Client Automated Resource and Eligibility System (CARES) for the receipt and filtering of the three types of PARIS matches: VA, Interstate and Federal.

Effective December 26, 2006, automation of the receipt and filtering of the PARIS matches began. Automation reduces the time spent on manual review and filtering and action on duplicate benefits. The matches are sent directly through the CARES system to the local Social Services offices or the local Health Departments. These matches are reviewed by the case manger and are coded into the system. Any match which can not be completed is referred to the MD Office of Inspector General (OIG) for investigation. In addition the OIG has access to the alerts allowing the tracking and monitoring of matches.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

Medical Assistance eligibility cards are mailed to eligible persons in Maryland.

The Income Maintenance Administration, Maryland Department of Human Resources has a list of community organizations, throughout the State, which have agreed to act as mail distribution points for homeless persons. These organizations include local departments of social services in each of the State's twenty-three counties, and Baltimore City. The list of organizations is added to as additional organizations agree to act as distribution points for mail.

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

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the state (whether statutory or as recognized by the courts of the state) concerning advance directives. If applicable, states should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special state limitations on living will declarations, proxy designation, process information and state forms, and identify whether state law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Maryland law recognizes three ways of making health care decisions for the future, including decisions about treatments needed to sustain life. These three ways are: a living will, a power of attorney for health care (often called a "durable power of attorney"), and a documented discussion with your physician.

1. Living Will

A living will is a specific legal form, approved by the Maryland Legislature, in which you can say that you do not want life-sustaining treatment if you are in a terminal condition. A living will speaks only to treatment at the last stage of a terminal condition. It goes into effect when your doctors conclude that you are no longer able to decide matters for yourself and that your condition is terminal.

You should particularly focus on whether you want your living will to contain a decision about food and water through tubes. If you decide that you do not want artificially supplied food and water, you must add a sentence to the standard living will form saying so.

2. Durable Power of Attorney for Health Care

A power of attorney for health care (often called a "durable power of attorney") is a legal document that lets you name someone you know and trust, your agent, to make health care decisions for you. You decide how much power your agent has and when the agent can exercise that power. If you want, you can give your agent broad power to make any decision about treatment that you could make.

Unlike a living will, a power of attorney for health care need not be limited to terminal conditions. It can allow your agent to deal with whatever treatment issues might come up.

In addition to giving your agent power to make decisions on your behalf, you can also use the power of attorney for health care to say what you want done in some situations. No one can predict every decision that might have to be made, but your written guidance about your wishes can help your agent - for example, by telling your agent whether you want life-sustaining treatment in case of terminal condition or permanent loss of consciousness.

3. Discussion With Physician

Adults often make health care decisions during discussions with their physicians. The physician describes the options and explains the pros and cons of each; but you make the final decision.

The same process can be used to decide about the possible use of life-sustaining treatment - what sorts of medical intervention you want, given particular situations that might occur. For example, you might decide in this way about the use of CPR (cardipulmonary resuscitation). If your decision is written in your medical record at the time it is made, it is legally effective and should be honored by your health care providers. You should look at what is written down to make certain that it reflects your wishes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

In accordance with Health-General Article §19-328 of the Annotated Code of Maryland, the State may, as an additional category 3 remedy, restrict new admissions if it is determined that a life-threatening health or fire safety deficiency exists.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Enforcement of False Claims Recovery Act

The Department of Health and Mental Hygiene (Department) will annually require each entity that makes or receives annual payments under the State Medicaid Plan of at least $5 million to certify that it complies with Section 6032 of the DRA. Each year, qualifying entities must complete and submit to the Department a form attesting compliance with Section 6032 of the DRA. The initial annual attestation form will be due no later than October 31, 2007. Forms will be due on December 31st of each subsequent year beginning December 31, 2007 for calendar year 2008 compliance. In addition, the Department will review qualifying entities for compliance during the course of its routine review of providers and contractors participating in the Maryland Medicaid Program starting January 1, 2008. The Maryland Department of Health and Mental Hygiene, Office of Health Services issued a Maryland Medical Assistance Program General Provider Transmittal No. 61, dated January 16, 2007, to all providers participating in the Maryland Medicaid Program describing the requirements of Section 6032 of the DRA, as it relates to employee education about false claims recovery.

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

Citation	
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

Medicaid State Plan Preprint

State/ Territory: Maryland

PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation		
Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)	4.44 X	The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.