STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 182

October 9, 2003

TO: Nursing Home Administrators

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

RE: Amendments to Nursing Facility Services Regulations

ACTION:
Proposed Regulations

PROPOSED EFFECTIVE DATE:
January 1, 2004

WRITTEN COMMENTS TO:
Michele Phinney
201 W. Preston Street, Room 521
Baltimore, Maryland 21201
(410) 767- 6499

PROGRAM CONTACT PERSON:
Stephen E. Hiltner, Supervisor
Nursing Home Program
(410) 767-1447

COMMENT PERIOD EXPIRES: November 3, 2003

The Maryland Medical Assistance Program proposes to amend Regulations .05, .07-.09, .10, .11, .16, .24, and .25 and to repeal Regulation .11-1 under COMAR 10.09.10 Nursing Facility Services. The amendments, as published in the *Maryland Register*, are attached.

Certain proposed amendments make permanent specific changes that have been in effect under emergency status as of July 1, 2003. These changes:

Eliminate the small facility region in the administrative and routine cost center.

Remove the two nursing facilities that are owned and operated by the State from the nursing home reimbursement system and base reimbursement for these facilities on Medicare principles of reasonable cost.

Clarify that a fringe benefit factor is added only to nursing home employee wages when processing nursing salary and hours of work data.

Eliminate behavior management, ostomy care, and injections as separate reimbursement items. The nursing time associated with these procedures will be merged into the per diem payments for each of the four levels of care. This change is needed to facilitate HIPAA compliance.

Employ the CPI-U index for Nursing Home and Adult Daycare as the index used to project nursing wages for fiscal year 2004.

Remove content that is no longer applicable. For example, Regulation .11-1 (pertaining to cost settlement adjustments) will be repealed because there are no longer any providers that qualify under its provisions. Likewise, this proposal will remove the provisions regarding additional nursing service payments that were specific to the period July 1, 2001 through June 30, 2003.

II. Other proposed amendments modify reimbursement parameters in order to reduce interim payments to nursing homes by $9.3 million for the period January 1, 2004 through June 30, 2004. This represents $5.3 million as a continuation of cost containment reductions already in effect under emergency status as of July 1, 2003, and an additional $4 million in reductions effective January 1, 2004 approved by the Board of Public Works. The modifications to reimbursement parameters will sunset June 30, 2005. The proposed regulations will:

Maintain the occupancy standard used to determine providers' allowable costs at the statewide average plus 1.5%.

Reduce the net capital value rental rate from 8.37 percent to 7.57 percent.

Reduce the ceilings in the administrative and routine cost center from 113 percent of median cost to 112 percent of median cost.

Reduce the efficiency payments in the administrative and routine cost center from 45 percent to 40 percent of the difference between a provider's cost and the ceiling for those providers with costs below the ceiling.

Reduce the ceilings in the other patient care cost center from 119 percent of median cost to 118 percent of median cost.

Reduce profit in the nursing cost center from 4.5 percent to 4.0 percent of reimbursement based on standard nursing rates for those providers with nursing costs less than reimbursement. The sum of reimbursement and profit cannot exceed reimbursement based on standard per diem nursing rates.

Any questions regarding this transmittal should be directed to the Nursing Home Section of the Division of Long Term Care Services at 410-767-1444.

SJT:seh
Attachment

cc: Nursing Home Liaison Committee

	Benefit (+) Cost (−)	Magnitude
D. On regulated industries or trade groups:		
Hospital Providers	(−)	$20,000,000
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

II Assumptions. (Identified by Impact Letter and Number from Section II.)

The Department's projected January through June 2004 expenditures will decrease by $10,000,000 (general funds) due to the hospital day limits placed on hospital services for fee for service recipients 21 years old or older.

D. The hospital day limits will negatively impact the hospital providers. The Health Services Cost Review Commission will be reviewing the impact of this day limit on hospital rates

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, 201 W. Preston Street, Room 521, Baltimore, Maryland 21201, or fax to (410) 333-7387, or email to regs@dhmh.state.md.us, or call (410) 767-6499 or 1-877-4MD-DHMH, extension 6499. These comments must be received by November 3, 2003.

10.09.06 Hospital Services

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

.04 Covered Services.

[The Program covers the following services:]

A. [Inpatient] *The Program covers the following inpatient* hospital services:

(1) Medically necessary services for the number of days, per admission including preoperative days certified by the utilization control agent when these services are:

(a) Necessary for the provision of diagnostic, curative, palliative, or rehabilitative treatment, [and]

(b) Described in the recipient's medical record in sufficient detail to support the invoices submitted for services[.];

(c) Within the Program's established day limits as described in §C of this regulation; and

(d) Emergency and elective admission approved by the concurrent review process conducted by the Utilization Control Agent (UCA) and described in §D of this regulation;

(2) (text unchanged)

B. [Outpatient.] *The Program covers the following outpatient* hospital services

(1)—(5) (text unchanged)

C. Hospital Day Limits.

(1) The Program's hospital day limits apply to the following types of providers

(a) Acute rehabilitation hospitals,

(b) Acute general hospitals; and

(c) Acute special hospitals.

(2) The Program's hospital day limits apply to services received by fee for service recipients who are 21 years old or older.

(3) The day limit is 95 percent of the average length of stay by diagnosis related groups.

(4) Hospital providers shall bill only for the days allowed under the Program's established day limit.

D. Concurrent Review Process.

(1) The concurrent review process shall be initiated by the hospital within the first 48 hours of admission, next business day for all emergency admissions.

(2) If the recipient remains hospitalized, additional days shall be certified by the UCA before the termination of the previously certified days.

(3) The hospital shall forward sufficient clinical information or documentation to the UCA that supports the need for continuing care. Information submitted shall include:

(a) Current medical health status;

(b) Treatment received to date; and

(c) Proposed treatment plan for continued stay.

(4) Reimbursement shall be denied for all unapproved days if the hospital fails to

(a) Comply with the concurrent review process during the hospital stay; or

(b) Submit information and request additional days before termination of previously certified days by the UCA.

.10 Billing and Reimbursement Principles.

A. — Q. (text unchanged)

R. Noncompliance with the Program's requirements as determined by the Utilization Control Agent shall result in nonpayment of the claim.

S. Hospital providers shall bill only for the days allowed under the Program's day limits as specified in COMAR 10.09.06.04C.

NELSON J. SABATINI
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.10 Nursing Facility Services

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

Notice of Proposed Action

[03-284-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.05, .07 — .09, .10, .11, .16, .24,** and **.25,** and repeal Regulation **.11-1** under **COMAR 10.09.10 Nursing Facility Services**. The proposed actions are to become effective January 1, 2004.

At this time, the Secretary of Health and Mental Hygiene is also withdrawing the proposed amendments to Regulations **.05, .07 — .09, .10, .11, .16, .24,** and **.25** and the repeal of Regulation **.11-1** under **COMAR 10.09.10 Nursing Facility Services** as proposed in the 30:15 Md. R. 1003 — 1007 (July 25, 2003).

Statement of Purpose

The purpose of this action is to make six adjustments to the nursing home regulations. First, the amendments modify reimbursement parameters in order to reduce interim payments to nursing homes by $9,300,000 ($4,650,000 in State funds) for the period January 1, 2004 through June 30, 2004. This represents $5,300,000 as a continuation of cost containment reductions already in effect under emergency status as of July 1, 2003, and an addi-

tional $4,000,000 in reductions effective January 1, 2004 approved by the Board of Public Works. The modifications to reimbursement parameters will sunset June 30, 2005. Second, they eliminate the small facility region in the administrative and routine cost center. Third, the amendments remove the two nursing facilities owned and operated by the State from the nursing home reimbursement system. Calculation of their reimbursement will be based upon Medicare principles of reasonable cost. The fourth change facilitates HIPAA compliance by eliminating behavior management, ostomy care, and injections as separate reimbursement items. The nursing time associated with these procedures will be merged into the per diem payments for each of the four levels of care. The fifth change clarifies that a fringe benefit factor is added only to nursing home employee wages when processing nursing salary and hours of work data. The last adjustment changes the index used to project nursing wages for fiscal year 2004. In addition to reimbursement system changes, these proposed regulations remove content that is no longer applicable as of July 1, 2003.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. During the period January 1, 2004 through June 30, 2004, these amendments are intended to reduce interim payments to nursing home providers by $9,300,000. These amendments will also increase federal matching funds by $1,250,000 for the two nursing homes owned and operated by the State.

II. Types of Economic Impact.	Revenue (R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency:		
(1) Medical Assistance Program	(E−)	$9,300,000
(2) DHMH	(R+)	$1,250,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (−)	Magnitude
D. On regulated industries or trade groups:		
Nursing home providers	(−)	$9,300,000
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

II. Assumptions. (Identified by Impact Letter and Number from Section II.)

A(1). The Program intends to reduce interim reimbursement to nursing home providers by $9,300,000 during the period January 1, 2004 through June 30, 2004. Of this amount, $640,000 is due to removing the costs associated with two State owned and operated nursing homes from the reimbursement calculation. The other savings are achieved through adjustments to various components of the reimbursement system. With an estimated 2,932,422 days of care, the total decrease in expenditures will total $3.17 per patient day. Fifty percent of this amount is State general funds and fifty percent is federal funds.

A(2). The Program intends to determine reimbursement for the two State owned and operated nursing home providers based on Medicare principles of reasonable costs, which will result in an increase in revenue of $1,250,000 in federal funds.

D. Interim payments to nursing home providers will be decreased by $9,300,000, as indicated in A(1), above.

Economic Impact on Small Businesses

The action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

Thirty-six nursing homes, which qualify as small businesses, are expected to account for 275,000 patient days during the period January 1 through June 30, 2004. At an average decrease in interim payments of $3.17 per day, the impact to small businesses during this period will be $871,750.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, 201 W. Preston Street, Room 521, Baltimore, Maryland 21201, or fax to (410) 333-7687, or email to regs@dhmh.state.md.us, or call (410) 767-6499 or 1-877-4MD-DHMH, extension 6499. These comments must be received by November 3, 2003.

.05 Limitations.

The following are not covered:

A. — B. (text unchanged)

[C. Occupational therapy services, unless part of a specialized rehabilitative therapy services program and according to Regulation .04F(2) of this chapter;

D. Physical therapy services, unless part of a specialized rehabilitative therapy services program and according to Regulation .04F(1) of this chapter;]

[E.] *C.* — [G.] *E.* (text unchanged)

.07 Payment Procedures — Maryland Facilities.

A. (text unchanged)

A-1. A provider may request an interim rate change in the nursing service cost center by submitting documentation to the Department or its designee to demonstrate that a recalculation of the provider's interim per diem rate would change by 2 percent or more. A provider may not request an interim rate change more than two times during the same rate year. [During the period July 1, 2002 through June 30, 2003, the revised interim per diem rates may be applicable for the entire year during which the request is submitted.]

B. The per diem average of all projected Medicaid payments for all cost centers shall be determined in accordance with the provisions of §A of this regulation. When this average exceeds the average determined if payments were to be made for Medical Assistance Program covered services on the basis of Medicare's principles of cost reimbursement, selected parameters of the rate determination process shall be adjusted downward in order to project a per diem patient average for Medicaid payments which does not exceed the Medicare Statewide class average. The following apply:

(1) The Medicare Statewide class average shall be determined from a sample of Maryland facilities using the following steps:

(a) The current interim costs for each cost center as reported on each facility's uniform cost report shall be projected from the midpoint of the facility's fiscal year to the midpoint of the rate year according to the procedures in Regulations .08E(2), .09E,[.10I] *.10E*, and .11D of this chapter.

(b) — (e) (text unchanged)

(2) (text unchanged)

(3) Adjustments to the parameters of the rate determination process for the Medical Assistance Program shall be effected in the following cumulative and repetitive sequence

until the per diem average of all projected Medicaid payments does not exceed the Medicare Statewide class average of §B(1) of this regulation:

(a) The net capital value rental rates specified in Regulation [*.10L(10)*] *.10G(9)* of this chapter shall be reduced by 0.005. If the per diem average of all projected Medicaid payments exceeds the Medicare Statewide class average, proceed with §B(3)(b) of this regulation.

(b) — (e) (text unchanged)

C. (text unchanged)

D. Nursing facilities that are owned and operated by the State are not paid in accordance with the provisions of §§A —.C of this regulation, but are reimbursed reasonable costs based upon Medicare principles of reasonable costs as described at 42 CFR Part 413. Aggregate payments for these facilities may not exceed Medicare upper payment limits as specified at 42 CFR §447.272.

.08 Rate Calculation — Administrative and Routine Costs.

A. (text unchanged)

B. The final per diem rate for administrative and routine costs in each reimbursement class is the sum of:

(1) (text unchanged)

(2) An efficiency allowance equal to the lesser of 50 percent *(40 percent for the period January 1, 2004 through June 30, 2005)* of the amount by which the allowable per diem costs in §B(1) of this regulation are below the maximum per diem rate for this cost center, or 10 percent of the maximum per diem rate for the cost center.

C. — D. (text unchanged)

E. Maximum per diem rates for administrative and routine costs in each reimbursement class shall be established according to the following:

(1) The current interim per diem costs for each participating comprehensive care facility in Maryland *paid in accordance with Regulation .07A — C of this chapter* and the number of paid Medical Assistance days of care from the most recent desk-reviewed uniform cost reports shall be used as the base to determine the maximum per diem rate for each reimbursement class;

(2) — (4) (text unchanged)

(5) The maximum per diem rate for each reimbursement class shall be 114 percent *(112 percent for the period January 1, 2004 through June 30, 2005)*, of the lowest aggregate indexed current interim per diem cost, from §E(1) of this regulation, which is equal to the aggregate indexed current interim per diem costs associated with at least 50 percent of the paid Medical Assistance days in the reimbursement class.

F. The [four] *three* reimbursement classes for the Administrative and Routine cost center are [based on facility size and geographic region as] specified under Regulation .24A of this chapter.

G. (text unchanged)

.09 Rate Calculation — Other Patient Care Costs.

A. — D. (text unchanged)

E. Maximum per diem rates for Other Patient Care costs in nursing facilities shall be established using the provisions described in Regulation .08E of this chapter except that 120 percent *(118 percent for the period January 1, 2004 through June 30, 2005)* of the lowest aggregate indexed current interim per diem cost which is equal to the aggregate indexed current interim costs associated with at least 50 percent of the paid Medical Assistance days in the reimbursement class shall be used instead of the percentage expressed in Regulation .08E(5) of this chapter and except that the table of monthly indices listed under Regulation .21 of this chapter shall be used instead of that presented in Regulation .20 of this chapter.

F. — G. (text unchanged)

.10 Rate Calculation — Capital Costs.

A. — B. (text unchanged)

C. The final Medical Assistance per diem reimbursement for capital in investor-operated *and non-investor-operated* facilities shall include:

(1) — (3) (text unchanged)

(4) [New] *Net* capital value rental; and

(5) (text unchanged)

[D. Investor-operated facilities shall have their final per diem reimbursements for capital determined by §C of this regulation, except that depreciation associated with mortgage financing "in-place" by December 1, 1982, not in excess of 1/40 of the per licensed bed appraised value limit specified in §L(4) of this regulation and 1/10 of the movable equipment allowance specified in §L(6) of this regulation, is to be used for reimbursement purposes instead of the net capital value rental if that portion of depreciation is greater than the net capital value rental. In addition, mortgage interest on financing in place by December 1, 1982 shall be limited to that associated with debt that does not exceed the total allowable appraised value limit from §L(6) of this regulation.

E. The provisions of §D of this regulation become inapplicable for any investor-operated facility as soon as there is any change in the arm's-length ownership of the facility after December 1, 1982.

F. When applying the provisions of §§C and D of this regulation, facilities owned by the State shall be assumed to have no debt.

G. Noninvestor-operated facilities with leases "in-place" by December 1, 1982 shall have final Medical Assistance per diem reimbursements for capital determined as the greater of the sum of the investor-operated elements in §C of this regulation or the sum of:

(1) Property taxes;

(2) Property insurance;

(3) Lease costs; and

(4) Depreciation on leasehold improvements.

H. As soon as the "in-place" lease terminates, becomes renegotiable, or an option to extend the lease is exercised, or as soon as the elements in §C of this regulation exceed the sum of the elements in §G of this regulation, the noninvestor-operated facility shall have its final reimbursements for capital determined forever after by §C of this regulation rather than §G of this regulation and not be subject to §D of this regulation.]

[I.]*D.* When applying the provisions of [§§G and H] *§C* of this regulation, the noninvestor-operated facility shall be assumed to have the following [for the calculation of §C of this regulation]:

(1) Debt equal to the amount which would remain outstanding at the midpoint of the rate year if the:

(a) Original amount mortgaged was equal to 85 percent of the appraised value of the facility at the time the provider's original lease for the facility was executed; *and*

[(b) Appraised value determined pursuant to §L of this regulation for any noninvestor-operated facility with an initial lease executed before March 31, 1983, will be deflated by 5 percent per year for the purposes of determining the appraised value in §I(1)(a) of this regulation; and]

[(c)] *(b)* Original mortgage was taken for a 20-year period with amortization calculated with constant payments and the interest rate as defined in [§I(2)] *§D(2)* or (3) of this regulation.

(2) — (3) (text unchanged)

(4) A lease with the owner of the facility. If the provider has a sublease with a previous provider, the original lease date of the previous provider with the owner of the facility shall apply to [§I(1) — (3)] *§D(1) — (3)* of this regulation.

(5) — (6) (text unchanged)

[J.] *E.* — [K.] *F.* (text unchanged)

[L.] *G.* The net capital value rental for those facilities which are subject to rate determination under §C of this regulation is determined through the following steps:

(1) — (2) (text unchanged)

(3) If the provider elects to protest an appraisal under [§L(1)] *§G(1)* or (2) of this regulation, written notification shall be filed with the Department within 90 days of receipt of the appraisal. Any protest which cannot be resolved administratively may be appealed under the provisions of Regulation .28 of this chapter.

(4) The allowable portion of the combined appraised value for land, building, and nonmovable equipment may not exceed a specified limit. This limit shall be established at $44,400 per licensed bed effective December 31, 1999, and shall be indexed forward as determined from [§J] *§E* of this regulation.

[(5) Facilities owned by the State need not be appraised, but shall have their capital values set at the limit established in §L(4) of this regulation. Under the provisions of §F of this regulation, facilities owned by the State shall be assumed to have no debt.]

[(6)] *(5)* The allowance for movable equipment shall be:

(a) (text unchanged)

(b) Indexed forward as determined from [§J] *§E* of this regulation; and

(c) Added to the appraised value determined from [§L(1)] *§G(1)*, (2), (4), and (5) of this regulation.

[(7)] *(6)* (text unchanged)

[(8)] *(7)* The amount of the allowable mortgage debt as of the midpoint of the fiscal year shall be subtracted from the allowable appraised value from [§L(6)] *§G(2)* of this regulation in order to establish the value of the net capital.

[(9)] *(8)* The debt information to be used in [§L(8)] *§G(7)* of this regulation shall be supplied to the Department or its designee by each facility in the form of a monthly amortization schedule within 60 days of the establishment of the debt.

[(10)] *(9)* The value of net capital from [§I(8)] *§G(7)* of this regulation shall be multiplied by 0.089 *(0.0757 for the period January 1, 2004 through June 30, 2005)* in order to generate the net capital value rental.

[M.] *H.* The rental rate[s] presented in [§L(10)] *§G(9)* of this regulation may be raised by up to 2 percentage points at the Department's discretion for facilities in a county or a group of counties in order to stimulate the addition of licensed beds to the existing stock.

[N.] *I.* (text unchanged)

[O.] *J.* Debt, and the interest on that debt, may not be allowed as a basis for reimbursable cost to the extent that the debt exceeds the allowable appraised value from [§L(6)] *§G(2)* of this regulation at the time of the creation of the debt or at the time the facility is opened, whichever is later. Once the allowable debt has been established, it shall then be amortized in accordance with Medicare principles.

[P.] *K.* For the purpose of an advance refunding of debt which creates savings to the State and is approved by the Program, interest on the refunding debt may not be limited to the allowable appraised value from [§L] *§G* of this regulation, but shall be allowed as a basis for reimbursable cost to the extent of the outstanding principal amount of the approved refunding debt. However, this provision shall apply only to the extent that federal funds are available for reimbursement.

[Q.] *L.* The provisions of [§§D — I, L, and M] *§§D, G, and H* of this regulation are not applicable to the capital costs for freestanding central offices of multiple-facility organizations.

[R.] *M.* Interest, whether actual or imputed in accordance with [§I] *§D* of this regulation, shall be reduced by investment income in accordance with the principles included under Regulation .08B(1) of this chapter.

.11 Rate Calculation — Nursing Services Costs.

A. (text unchanged)

B. Interim Reimbursement.

(1) (text unchanged)

(2) Interim per diem rates shall be reduced for any provider which, based on the most recently desk reviewed actual allowable costs, is projected to spend less than its standard per diem rates. Interim per diem rates shall be reduced by 95 percent of the difference between the:

(a) Provider's interim reimbursement under §B(1) of this regulation [less the amount calculated under §G(10)(l) of this regulation]; and

(b) Amount calculated under [§B-1(2)] *§C(2)* of this regulation.

[(3) For a provider whose final nursing payments are to be adjusted in accordance with the provisions of Regulation .11-1 of this chapter, the amount of the projected adjustment shall be added to allowable costs before the calculation of any interim rate reduction.

B-1. The final Medical Assistance reimbursement for nursing services for the period July 1, 2001 — June 30, 2003 is the lesser of the:

(1) Interim reimbursements under §B(1) of this regulation; or

(2) Sum of the:

(a) Provider's allowable nursing service costs;

(b) Amount as specified in §§B-2 and B-3 of this regulation;

(c) Amount of the adjustments resulting from the application of the provisions of §G(10)(e) — (g) of this regulation; and

(d) Amount of the interim reimbursements for specialized support surfaces in accordance with the provisions of §H-1 of this regulation.

B-2. The amount in §B-1(2)(b) of this regulation, subject to the maximums specified in §B-3 of this regulation, shall be the greater of:

(1) The lesser of the:

(a) Amount by which the provider's interim per diem reimbursements exceed the provider's per diem costs; or

(b) Amount by which the provider's interim per diem reimbursements exceed the provider's per diem costs during the provider-selected period of July 1, 2002 — December 31, 2000 or July 1, 2000 — June 30, 2001, adjusted by application of the salary and wage indices specified in Regulation .23 of this chapter for the period July 1, 2001 — June 30, 2002 and by the provisions of §G(7) of this regulation for the period July 1, 2002 — June 30, 2003; or

(2) For providers with nursing service costs lower than their interim reimbursements minus the amount calculated under §G(10)(l) of this regulation, the difference between the provider's allowable nursing service costs and the amount calculated under §B(1) of this regulation excluding the amount calculated under §G(10)(l) of this regulation.

B-3. The maximum amount under §B-1(2)(b) of this regulation is calculated as follows:

(1) For the period July 1, 2001 — November 30, 2001, 5 percent of the difference between the amount calculated under §B(1) of this regulation and the amount calculated under §G(10)(l) of this regulation;

(2) For the period December 1, 2001 — June 30, 2002, 4.5 percent of the difference between the amount calculated under §B(1) of this regulation and the amount calculated under §G(10)(l) of this regulation; and

(3) For the period July 1, 2002 — June 30, 2003, 5 percent of the difference between the amount calculated under §B(1) of this regulation and the amount calculated under §G(10)(l) of this regulation.]

C. The final Medical Assistance reimbursement for nursing services is the lesser of:

(1) (text unchanged)

(2) The sum of the:

(a) (text unchanged)

(b) Amount of the reimbursements calculated under §B(1) of this regulation multiplied by 0.05 *(0.040 for the period January 1, 2004 through June 30, 2005)*;

(c) Amount of the adjustments resulting from the application of the provisions of [§G(10)(e) — (g)] *§G(9)(e) — (g)* of this regulation, and

(d) (text unchanged)

D. — F. (text unchanged)

G. [Except as indicated in §G(7) of this regulation, the] *The* resident-specific standard reimbursement rates shall be determined by the following steps:

(1) (text unchanged)

(2) Each Maryland facility covered by these regulations which fails to comply with §G(1) of this regulation shall incur a 1 percentage point reduction in its applicable rental rate presented in Regulation [.10L(10)] *.10G(9)* of this chapter.

(3) (text unchanged)

(4) Apply the fringe benefit factor (the ratio of salaries and wages plus employee benefits to salaries and wages) for each reimbursement class as computed annually from Schedule D of the indexed uniform cost report to the hourly wages of each nursing home employee for each personnel category to compute wages plus benefits.

[(4)] *(5)* [Inflate] *Except for the period July 1, 2003 through June 30, 2004, during which the hourly wages are inflated to the mid-point of the rate year by application of the Consumer Price Index for All Urban Consumers (CPI-U), Nursing Homes and Adult Daycare, from U.S. Department of Labor, Bureau of Labor Statistics, CPI Detailed Report, Table 4, inflate* each hourly wage in each of the five personnel categories within each reimbursement class to the midpoint of the rate year using the salary and wage indices specified in Regulation .23 of this chapter, and the procedure specified in Regulation .08E(2) of this chapter[.]

[(5)] *(6)* Array the hourly [indexed] wages within each reimbursement class and personnel category in descending order along with the number of hours each wage represents, and select the lowest hourly wage in each reimbursement class/personnel category combination which is equal to or above the hourly wages associated with at least 75 percent of all the hours in the combination.

[(6) Apply the fringe benefit factor (the ratio of salaries and wages plus employee benefits to salaries and wages) for each reimbursement class as computed annually from Schedule D of the indexed uniform cost report to the hourly wages for each personnel category to compute wages plus benefits.]

[(7) For the period July 1, 2002 through June 30, 2003, the hourly wages plus benefits shall be determined by adjusting the hourly wages plus benefits for the period July 1, 2001 through June 30, 2002 by the average annual percent change in these wages and benefits used for establishing rates for the 3 fiscal years before July 1, 2002.

[(8)] *(7)* Multiply the hourly wages plus benefits applicable to each reimbursement class by procedure and activity times using the weights associated with each personnel category to determine the nursing service unadjusted standard per diem reimbursement rates for each reimbursement class. Current procedure and activity times and personnel category weights are established by the table under Regulation .25B of this chapter, and shall be recalibrated as follows:

(a) Effective July 1, [2004] *2005*, and at subsequent 7-year intervals, procedure and activity times and personnel category weights shall be recalibrated based on a work measurement study of nursing procedures in nursing homes. The work measurement study sample may not include:

(i) — (v) (text unchanged)

(b) In any year [with the exception of the period July 1, 2002 through June 30, 2003] that procedure and activity times and personnel category weights are not recalibrated based upon a work measurement study, times and weights shall be revised based on annual wage survey data modified to exclude those providers which during the wage survey period met any of the criteria referenced in [§G(8)(a)] *§G(7)(a)* of this regulation.

[(9)] *(8)* (text unchanged)

[(10)] *(9)* Make the following adjustments to generate the standard per diem reimbursement rates for Nursing Services:

(a) — (i) (text unchanged)

(j) Determine the average per diem cost for a respirator support system from the fee schedule for respirator equipment established in accordance with COMAR 10.09.27, and add this amount to the results from §G(9)(i) of this regulation for ventilator care; *and*

(k) Determine the conversion factor for nonsurgical services used by the federal [Health Care Financing Administration] *Centers for Medicare and Medicaid Services* for calculating physician reimbursement based upon relative value units, multiplied by 0.25, and add this amount to the results from §G(9)(j) of this regulation for ventilator care[; and].

[(l) Subject to budget appropriations, for each rate year during the period July 1, 2001 through June 30, 2003, factor additional funds, as authorized under Ch. 212, Acts of 2000, into reimbursement for nursing services by adjusting the rates for light care, light care-behavior management, moderate care, moderate care-behavior management, heavy care and heavy special care as follows:

(i) This adjustment shall be achieved by adding nurse aide hours to the reimbursement rate calculations proportionate to the number of nurse aide hours factored

into each of these ADL classifications under §G(8) of this regulation; and

(ii) This adjustment shall account for the projected number of Medical Assistance days in each rate year and the percent of days in each ADL classification.]

H. — Q. (text unchanged)

[R. In recognition of the nursing time required to assist and treat patients with behavior management problems, a provider shall be paid at a differential rate to account for the added nursing time required by these patients, as follows:

(1) Behavior management rates shall apply to light and moderate level patients only;

(2) The nursing time and personnel category weights associated with days of care for behavior management patients are indicated under Regulation .25B of this chapter;

(3) The Program shall establish behavior management criteria and documentation requirements; and

(4) The utilization control agent shall review the documentation required in §R(3) of this regulation.]

[S.] *R.* — [U.] *T.* (text unchanged)

.16 Selected Costs — Allowable.

A. — E. (text unchanged)

F. Bed Occupancy.

(1) The per diem cost determined for a provider, or a distinct part thereof in a multilevel facility, shall be calculated at the actual occupancy of the nursing facility beds or at the Statewide average occupancy of nursing facility beds, based on the cost reports used to set the current interim rates, plus 0.5 percent [(1.5 percent for the period July 1, 2002 — June 30, 2003)] *(1.5 percent for the period July 1, 2003 through June 30, 2005,*whichever is higher, for the calculation of ceilings, current interim costs, and final costs in the cost centers of Administrative and Routine, and Other Patient Care.

(2) The per diem cost determined for a provider, or a distinct part of it in a multilevel facility, shall be calculated at the actual occupancy of the nursing facility beds or at the Statewide average occupancy of nursing facility beds, based on the cost reports used to set the current interim rates, plus 0.5 percent [(1.5 percent for the period July 1, 2002 — June 30, 2003)] *(1.5 percent for the period July 1, 2003 through June 30, 2005,*whichever is higher, for all Capital cost items exclusive of the net capital value rental.

(3) The per diem rate determined for a provider, or a distinct part of it in a multilevel facility, shall be calculated at the actual occupancy of the nursing facility beds plus 95 percent of licensed capacity of the non-nursing facility beds, or at the Statewide average occupancy of nursing facility beds, based on the cost reports used to set the current interim rates, plus 0.5 percent [(1.5 percent for the period July 1, 2002 through June 30, 2003)] *(1.5 percent for the period July 1, 2003 through June 30, 2005,* plus 95 percent of licensed capacity of the non-nursing facility beds, whichever is higher, for the net capital value rental.

(4) — (8) (text unchanged)

.24 Reimbursement Classes.

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

(1) Facilities [with less than 70 total licensed beds regardless of geographic region;

(2) Facilities with 70 total licensed beds or more] in the Baltimore region consisting of Baltimore City and the following counties:

(a) — (e) (text unchanged)

[(3)] *(2)* Facilities [with 70 total licensed beds or more] in the Washington region consisting of the following counties:

(a) — (c) (text unchanged)

[(4)] *(3)* Facilities [with 70 total licensed beds or more] in the nonmetropolitan region consisting of the following counties:

(a) — (o) (text unchanged)

B. The three reimbursement classes for the Other Patient Care cost center are based on the county groupings as specified in §A of this regulation [except that these geographic regions are to be used for all facilities regardless of licensed capacity].

C. (text unchanged)

.25 Nursing Service Personnel and Procedures.

A. (text unchanged)

B. Procedure and Activity Times and Personnel Category Weights. (table proposed for repeal)

ADL Classifications and Procedure Types	*Daily Hours Required*	*Personnel Categories*	*Weights*
Light care	*2.1018*	*DON*	*0.0231*
		RN	*0.1348*
		LPN	*0.2522*
		NA	*0.4582*
		CMA	*0.1318*
Moderate care	*3.3148*	*DON*	*0.0169*
		RN	*0.1217*
		LPN	*0.1807*
		NA	*0.6063*
		CMA	*0.0745*
Heavy care	*4.0116*	*DON*	*0.0138*
		RN	*0.1134*
		LPN	*0.2008*
		NA	*0.6165*
		CMA	*0.0555*
Heavy special care	*4.0116*	*DON*	*0.0138*
		RN	*0.1134*
		LPN	*0.2008*
		NA	*0.6165*
		CMA	*0.0555*
Decubitus ulcer care	*0.2579*	*RN*	*0.2500*
		LPN	*0.7500*
Communicable disease care	*3.3500*	*RN*	*0.1821*
		LPN	*0.2358*
		NA	*0.4388*
		CMA	*0.1433*
Central intravenous line	*0.3917*	*RN*	*1.0000*
Peripheral intravenous care	*1.3021*	*RN*	*0.4976*
		LPN	*0.5024*
Tube feeding	*0.5145*	*RN*	*0.2275*
		LPN	*0.7725*

ADL Classifications and Procedure Types	*Daily Hours Required*	*Personnel Categories*	*Weights*
Ventilator care	*4.1100*	*RN*	*0.5094*
		LPN	*0.4906*
Turning and positioning	*0.4405*	*RN*	*0.0156*
		LPN	*0.0177*
		NA	*0.9629*
		CMA	*0.0038*
Oxygen / aerosol therapy	*0.1567*	*RN*	*0.2104*
		LPN	*0.7896*
Suction / tracheotomy	*0.3625*	*RN*	*0.1648*
		LPN	*0.8352*

NELSON J. SABATINI
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.19 Transportation Grants

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

Notice of Proposed Action

[03-285-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.02**, **.05**, and **.09** under **COMAR 10.09.19 Transportation Grants**.

Statement of Purpose

The purpose of this action is to implement a $1 copayment per medical visit for recipients, in accordance with the recent budget reduction. This action also amends certain terminology describing Medicaid services to be consistent with terminology used in other program areas.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. This action is intended to reduce the grants to local jurisdictions for the provision of nonemergency transportation to nonemergency medical services. Accordingly, the grantees will assess a copayment of $1 per medical visit.

II. Types of Economic Impact	Revenue (R+/R–) Expenditure (E+/E–)	Magnitude
A. On issuing agency: Medical Assistance Program	(E–)	$400,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	
D. On regulated industries or trade groups:	NONE	
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public: Medicaid recipients using transportation services	(–)	$400,000

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. The copayment will result in a reduction in expenditures of $400,000, $200,000 of which is federal matching funds.

F. Recipients will incur a $1 copayment per medical visit. This will cumulatively amount to $200,000 in FY 2004.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, 201 W. Preston Street, Room 521, Baltimore, Maryland 21201, or fax to (410) 333-7687, or e-mail to regs@dhmh.state.md.us, or call (410) 767-6499 or 1-877-4MD-DHMH, extension 6499. These comments must be received by November 3, 2003.

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) — (2) (text unchanged)

(3) "Copayment" means the amount a recipient is liable to pay for transportation to or from a medical visit.

[(3)] *(4)* — [(13)] *(14)* (text unchanged)

.05 Limitations.

Monies from a grant provided under these regulations may not be used to pay for the following:

A. — P. (text unchanged)

Q. Transportation between a [community] *psychiatric* rehabilitation program [(CRP)] *(PRP)* and the recipient's home;

R. (text unchanged)

S. Transportation to or from services that are not medically necessary[.]; *or*

T. Copayment of $1 per medical visit payable by the recipient, whether or not it is collected.

.09 Responsibility to Recipients.

A grantee is expected to meet the transportation needs of recipients in a grantee's county out of grant funds *plus the $1 per medical visit copayment for which recipients are liable*. In those circumstances when the grant funds are insufficient, the grantee shall contact the Program's staff specialist for transportation service, who shall evaluate and assist in resolving transportation requests. A grantee may not refuse services or assistance to a recipient who requests transportation on the basis that the grantee's grant funds have been exhausted *or that the recipient is unable to pay the copayment*.

NELSON J. SABATINI
Secretary of Health and Mental Hygiene