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

State of Maryland

Introduction

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

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

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

Reimbursement Limitations:

A. The Department may not reimburse the claims received by the Program for payment more than 12 months after the date of services.

B. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:

(1) Approved, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and

(2) Denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

C. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 12 months of the earliest date of service.

D. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 12 months period, or within 60 days of rejection, whichever is later.

E. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 12 months of the date on which eligibility was determined.

Payment for Services: Methods and Standards for Establishing Payment Rates

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

I. Inpatient Hospital Services:

In 1977, the Department of Health, Education and Welfare (now the Department of Health and Human Services) granted the State of Maryland a waiver from Medicare reimbursement principles in favor of reimbursement based on approved rates under a "hospital prospective rate setting experiment." Under this All Payer Hospital Rate System, all Maryland payers, including Medicare and the Program, reimburse inpatient hospital services at prospective rates reviewed and approved by the Maryland Health Services Cost Review Commission (HSCRC). The All Payer Hospital Rate System is now codified in Section 1814(b) of the Social Security Act.

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

At the initiation of the All Payer Hospital Rate System, the HSCRC set each hospital's unit rates based on cost. Subsequently, the HSCRC adjusts each hospital's approved rates for such items as inflation, volume changes, pass-through costs, and uncompensated care through a public annual update factor process. The HSCRC establishes approved rates for units of service in the various revenue producing departments (rate centers) for each hospital.

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

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

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

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

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

B. The Program will make no direct reimbursement to any Maryland State-operated chronic hospital, or psychiatric hospital.

C. An acute general or special hospital other than private psychiatric hospitals whose rates are not set by the HSCRC will be reimbursed according to the lesser of:

1. Medicare standards for retrospective cost reimbursement described in 42 CFR Part 413; or

2. On the basis of charges if less than reasonable cost.

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

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

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

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

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

Review of cost reports and revenue statements produced a 16% reduction on average and establishes the recommended PPS rate at 84% of the HSCRC rate. Payment for administrative days in private psychiatric hospitals will be made according to: (1) A projected average Medicaid nursing home payment rate, or (2) the administrative day rate for recipients waiting placement in a residential treatment center.

E. Private freestanding pediatric rehabilitation hospitals in Maryland not approved for reimbursement according to the HSCRC rates shall be reimbursed for inpatient expenditures using a prospective payment system consisting of per diem rates based on categories of service on the providers fiscal year cost report for 2004 after audit and adjustments. The base per diem rates shall be adjusted annually by a market basket update factor in the Centers for Medicare and Medicaid Annual Update factors for Long Term Care Hospital Prospective Payment System.

II. Disproportionate Share Payments

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

A. A Maryland hospital shall be deemed a disproportionate share hospital for purposes of a disproportionate share payment if:

1. The hospital's Medicaid (Title XIX) inpatient utilization rate as defined in section 1923 (b) (2) is at least one standard deviation above the mean Medicaid (Title XIX) inpatient utilization rate for Maryland hospitals that are Medicaid providers; or

2. The hospital's low-income utilization rate, as defined in section 1923(b)(3), exceeds twenty-five percent (25%); and

3. The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetrical services to individuals who are entitled to Medical Assistance for such services under Maryland Medicaid's State Plan, except that the requirements of A(3) shall not apply to a hospital if:

   a. Inpatients are predominantly individuals under 18 years of age; or

   b. It did not provide non-emergency obstetric services as of December 22, 1987; and

4. The hospital's Medicaid inpatient utilization rate is not less than 1 percent.

B. Disproportionate Share Payments for Disproportionate Share Hospitals

1. For acute care general, free-standing chronic care, and free-standing pediatric-rehabilitation hospitals, the DSP shall equal the minimum DSP rate required by federal law.

   For these "types" of hospitals not governed by the Maryland Medicare Waiver, additional adjustment payments in the amount described below in items 2a through 2f shall be made.

   For these "types" of hospitals governed by the Maryland Medicare Waiver, rates set in accordance with the Maryland Waiver already include the DSP, and no additional payment will be made.

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

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

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

2-b. For free-standing psychiatric hospitals with charity care inpatient costs less than or equal to 40 percent of total inpatient hospital costs, the disproportionate share payment shall equal the minimum DSP required by federal law.

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

2-d. For free-standing rehabilitation hospitals with charity care inpatient costs less than or equal to 20 percent of total inpatient hospital costs. the disproportionate share payment shall equal the minimum required by federal law.

2-e. One or more payments shall be made for each year which, in the aggregate, shall cover the entire fiscal year. DSH status and DSP depends on DSHs providing necessary qualifying information to the Department on a timely basis. DSP for any federal fiscal year are subject to the DSH allotment set for Maryland.

2-f. DSP for a hospital will not exceed limits established in accordance with section 1923(g) of the Social Security Act.

C. Any redistribution of an overpayment for DSH shall first be redistributed within the same category of facility as the overpayment, i.e. Public Psychiatric Hospitals, Public Rehab Hospitals or Private General Hospitals. The redistribution shall be to all hospitals in the group who have not received the maximum for which they are eligible. The distribution shall be based on the percentage of each hospital's unused capacity to the total unused capacity for the category. If all available overpayments are not allocated in this manner the remaining categories shall be combined into one group and the remaining overpayment amount shall be based on the percentage of each hospital's available capacity to the total available capacity for all remaining hospitals.

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

A. Inpatient:

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

- Factor 1 is the report period cost-to-charge ratio. This factor, which is determined by an analysis of the hospital's most recent cost report performed by the Maryland Medical Assistance Program or its designee, establishes the cost-to-charge ratio for the hospital during the cost report period.

- Factor 2 is the cost-to-charge projection ratio. This factor, which is determined by an analysis of the hospital's three most recent cost reports performed by the Program or its designee, projects the cost-to-charge ratio from the cost report periods two years prior to the latest cost report to the prospective payment period. The annual rate of change is applied from the mid-point of the report period used to develop Factor 1 to the mid-point of the prospective payment period. To reflect the accelerating pace of cost-to-charge ratio decreases, Factor 2 shall not be greater than 1.000.

- Factor 3 is the efficiency and economy adjustment. This factor represents the fraction of the hospital's costs which the MMAP finds to be efficiently and economically incurred. In making this finding, the MMAP compares the hospital's cost of providing care to program recipients classified into APR-DRGs/age categories with the costs of providing care to identically classified program recipients in Maryland hospitals. In order to recognize the possibility that the severity of illness within APR-DRG/age categories may be greater for program recipients treated in D.C. hospitals than in Maryland hospitals, the MMAP will adjust cost differences for positive APR-DRG/age adjusted length-of-stay (LOS) differences between the hospital and the Maryland LOS. For hospitals other than Rehabilitation Hospital, the MMAP shall give 80% credit for positive LOS differences for DRGs other than 462 (Rehabilitation) the cost of longer stay days is approximately 30% of the cost of average days. For hospitals with stays in DGR 462 the MMAP shall give 100% credit for the positive LOS difference because in DRG 462 the cost of longer stay days equals the cost of an average day.

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

(1) Cumulative D.C. labor costs increase per full time equivalent (FTE) is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is greater than the cumulative increase in Average Hourly Earnings (AHE) for Hospital Workers as reported by the Bureau of Labor Statistics, then the Program will use information as supplied in the 1990-1991 edition of Hospital Statistics; or if,

(2) Cumulative D.C. labor costs increase per FTE is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is less than the cumulative increase in AHE, then the 1989 data supplied in the 1990-1991 edition of Hospital Statistics will be adjusted to recognize the portion of the D.C. increase in labor cost per FTE which does not exceed the cumulative AHE; or if

(3) Cumulative D.C. labor costs increase per FTE is less than the cumulative Maryland labor cost increase per FTE in any edition of Hospital Statistics, then the labor market difference shall be measured using that current issue of Hospital Statistics.

- Factor 4 is the uncompensated care ratio consisting of charity care and bad divided by net revenue from the Medicare cost report.

  (1) In no case shall the MMAP pay more than charges, thus the percent of charges paid shall not be greater than 1.000.

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

  (3) For acute children's hospitals, the MMAP will pay based on maintaining the revenue at fiscal 2009 level. For all other DC hospitals the revenue shall be maintained at the 2010 level.

- Factor 5: Beginning July 1, 2011 rates calculated according to the four factors above should be adjusted upward by 2.0 percentage points.

IV. Out of State Hospitals

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

B. For covered inpatient organ transplant services an out-of-State hospital, excluding a D.C. hospital, shall be reimbursed the lesser of:

1. The Medicare DRG rate;

2. 70 percent of charges;

3. The amount reimbursable by the host state's Title XIX agency.

C. For inpatient services, a hospital licensed special-rehabilitation, except a hospital located in D.C., shall be reimbursed the lesser of its charges or:

1. The amount reimbursable by the host state's Title XIX agency.

2. If the host state's Title XIX agency does not cover inpatient rehabilitation hospital services, the amount reimbursable by the Title XVIII intermediary; or

3. If the methodologies in 1 and 2 above are not applicable, the rate of reimbursement will be according to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR 413, or on the basis of charges if less than reasonable cost.

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

D. Out of State Psychiatric Hospitals costs are reimbursed based on Medicare's retrospective cost reimbursement principles. Their interim rate is based on a per diem amount.

1. Medicare standards for retrospective cost reimbursement described in 42 CFR Part 413; or

2. On the basis of charges if less than reasonable cost.

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

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

OS Notification

State/Title/Plan Number:	**Maryland 11-014A**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**May 30, 2012**
Fiscal Impact in Millions:	**FY 2011 $0** **FY 2012 $0**

Number of Potential Newly Eligible People: 0
Eligibility Simplification: No
Provider Payment Increase: No
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail: **Effective July 1, 2011, MD SPA 11-014A separates MD's previous Section 4.19A&B into separate sections 4.19A and 4.19B. SPA 11-014A establishes 4.19A for reimbursement of inpatient services. Under a Medicare Waiver approved by DHHS in 1977, Maryland hospital rates are set for all payers by the Maryland Health Services Cost Review Commission (HSCRC). The Waiver and rates have to be approved by Medicare. This all payer system is codified in the SSA in Section 1814(b). The initial hospital rates are based on hospital costs with annual adjustments for inflation, utilization, pass-through costs, and uncompensated care.**

PPC adjustments continue in a supplement to 4.19A.

SPA 11-014A does not modify reimbursement methodology, therefore public notice was not required and FFP impact is zero ($0).

Other Considerations:

The State's only Urban Indian Organization was consulted on this SPA, and had no comments.

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and the approval of the SPA is not in violation of ARRA provisions.

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