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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 20-0010

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

March 16, 2021

Dennis R, Schrader
Medicaid Director
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

RE: **Maryland State Plan Amendment (SPA) Transmittal Number 20-0010**

Dear Mr. Schrader:

We have reviewed the proposed amendment to Attachment 4.19-B of Maryland's state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on October 22, 2020. This plan amendment creates a public Emergency Service Transporter Supplemental Payment Program (ESPP) for public emergency service transportation providers.

Based upon the information provided by the State, we are approving the amendment with an effective date of October 1, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Gary Knight at 304.347.5723 or Gary.Knight@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20 — 0010

2. STATE: MD

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

~~N/A~~ 42 CFR 431.53

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 60,000
b. FFY 2022 $ 80,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Att. 4.19B pg. 40A-40E (20-0010)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Att. 4.19B pg. 40A-40E (NEW)

10. SUBJECT OF AMENDMENT

The purpose of this amendment is to create a public Emergency Service Transporter Supplemental Payment Program (ESPP) for public emergency service transportation providers.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

[redacted]

13. TYPED NAME: Tricia Roddy

14. TITLE: Assistant Medicaid Director

15. DATE SUBMITTED: October 22, 2020

16. RETURN TO

Dennis R. Schrader
Medicaid Director
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/22/2020

18. DATE APPROVED: 3/16/2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL

[redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Director, FMG Division of Reimbursement Review

23. REMARKS

3/10/2021: Maryland agreed to P&I adding 42 CFR 431.53 in Block 6

3. Emergency Service Transporter Supplemental Payment Program (ESPP).

(a) Reimbursement rates for Emergency Service Transporters are outlined in Attachment 4.19-B, page 40.

(b) SUPPLEMENTAL PAYMENT FOR JURISDICTIONAL EMERGENCY MEDICAL SERVICES OPERATIONAL PROGRAMS

Effective October 1, 2020, Jurisdictional Emergency Medical Services Operational Programs (JEMSOPs) that meet the specified requirements outlined in Section 3(c) below and provide ground emergency transportation services to Medicaid recipients as defined in Attachment 3.1A page 30, will be eligible for a supplemental payment. This supplemental payment applies to Emergency Transportation Services (ETS) rendered to Medicaid recipients by eligible JEMSOPs on or after October 1, 2020. EPSS is a voluntary program, and JEMSOPs are not required to participate.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to Emergency Service Transporters in accordance with Attachment 4.19-B, page 40 that eligible entities receive for ETS services rendered to eligible Medicaid recipients. Total reimbursements under the ESPP program are capped (including supplemental payments) at one hundred percent of actual costs. The Maryland Department of Health (the Department) will recognize a supplemental payment equal to the total allowable Medicaid costs of eligible JEMSOPs for providing services as set forth below.

(c) To qualify for supplemental payments, providers must meet all of the following:

1. Be enrolled as a Medicaid provider for the period being claimed on their annual cost report;
2. Provide ground Emergency Transport Services to Medicaid recipients; and
3. Be a “Jurisdictional Emergency Medical Services Operational Program," which is defined under COMAR 30.03.02 as: “an institution, agency, corporation, or other entity that has been approved by the Emergency Medical Service Board to provide oversight for each of the local government and State and federal emergency medical services programs.”

Providers meeting all of these qualifications will be considered “Eligible Providers.”

(d) Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning those expenses to the Medicaid program, except as expressly modified below.

2. The total uncompensated care costs of each Eligible Provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each Eligible Provider providing ETS to Maryland Medicaid recipients, net of the amounts received and payable from the Maryland Medicaid program and all other sources of reimbursement for such services provided to Maryland Medicaid recipients. If the Eligible Providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

(e) Cost Determination Protocols

1. An Eligible Provider's specific allowable cost per-ETS transport rate will be calculated based on the provider's financial data reported on the state-approved cost report. The per-ETS transport cost rate will be the sum of actual allowable direct and indirect costs of providing ETS divided by the actual number of emergency transports provided for the applicable service period.

2. Direct costs for providing ETS include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services ETS, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the ETS.

3. The total percentage of time spent on ETS calls throughout the cost reporting period will be calculated using Computer Aided Dispatch (CAD)/trip allocation statistics and used as an allocation methodology for those costs "shared" between ETS vs. Non-ETS

divisions. Eligible Providers will allocate shared Capital Related and Salaries & Benefits (CRSB) costs based on CAD/trip allocation statistics.

4. Indirect costs are determined in accordance to one of the following options.
    a. Eligible Providers receiving more than $35 million in direct federal funding in a calendar year must either have a Cost Allocation Plan (CAP) or a cognizant department approved indirect rate agreement in place with its federal cognizant department to identify indirect cost. If the Eligible Provider does not have a CAP or an indirect rate agreement in place with its federal cognizant department and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.

    b. Eligible Providers receiving less than $35 million of direct federal funding in a calendar year are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, Eligible Providers may use methods originating from a CAP to identify its indirect cost. If the Eligible Provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.

    c. Eligible Providers receiving no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
        i. A CAP with its local/municipal government
        ii. An indirect rate negotiated with its local government
        iii. Direct identification through use of a cost report

    d. If the Eligible Provider never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost.

(f) Cost Settlement Process

1. The payments and the number of ETS transports reported in the as-filed cost report will be reconciled with the Department's Medicaid Management Information System (MMIS) reports generated for the cost reporting period within 12 months of the as-filed cost report deadline. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

2. Each Eligible Provider will receive an annual lump sum payment in an amount equal to the total of the uncompensated care costs as defined in the above Supplemental Reimbursement Methodology – General Provisions Section 3(d)(2).

3. The Department will perform a final reconciliation where it will settle the Eligible Provider's annual cost report as reviewed and/or audited within the following calendar year. The Department will compute the net ETS allowable costs using reviewed and/or audited per-ETS cost, and the number of fee-for-service ETS transports reflected in the updated MMIS reports. Actual net allowable costs will be compared to the total Medicaid reimbursement paid to the provider for eligible services, including claims payments, third party liability, copayments, spenddown, settlement payments made, and any other source of reimbursement received by the Eligible Provider for the period. If, at the end of the final reconciliation, it is determined that the Eligible Provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the Eligible Provider will receive a final supplemental payment in the amount of the underpayment.

(g) Eligible Provider Reporting Requirements

1. Cost reports are due no later than 180 days after the last day of the State Fiscal Year. A request for an extension shall only be approved when a provider's operations are significantly and/or adversely affected due to extraordinary circumstances, which the provider has no control, such as, flood or fire. The written request must include a detailed explanation of the circumstances supporting the need for additional time and be postmarked within the 180 days after the last day of the applicable State Fiscal Year. Filing extensions may be granted by the Department for good cause, but such extensions are made at the discretion of the Department.

2. Only cost reports from Eligible Providers as defined in Section 3(c) will be accepted.

3. Participating Eligible Providers who meet the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with 3(c) through 3(f) for services provided on or after October 1, 2020.

    a. Eligible Providers will be paid interim rates equal to the Medicaid reimbursement rates paid to other ETS providers in accordance with Attachment 4.19-B, page 40. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate

transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.

b. Eligible Providers will submit a state approved cost report annually, on a form approved by the Department.

c. "Allowable costs" will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 CFR, part 200 as implemented by HHS at 45 CFR, part 75.
    i. "Direct costs" are those costs that are identified by 45 CFR 75.413 that:
        1. Can be identified specifically with a particular final cost objective (to meet emergency transportation service requirements), such as a federal award, or other internally or externally funded activity; or
        2. Can be directly assigned to such activities relatively easily with a high degree of accuracy.
    ii. "Indirect costs" means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.

d. Eligible Provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio, to Medicaid transports associated with paid claims for the dates of service covered by the submitted cost report.