PROPOSAL
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Title 10
MARYLAND DEPARTMENT OF HEALTH

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.77 Urgent Care Centers

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

Notice of Proposed Action

[22-322-P]

The Secretary of Health proposes to amend Regulations **.01**, **.03—.07**, and **.10** under **COMAR 10.09.77 Urgent Care Centers**.

Statement of Purpose

The purpose of this action is to:

(1) Ease the condition for participation that an urgent care center have a physician on-site during hours of operation by allowing certified nurse practitioners and physician assistants to satisfy this requirement;

(2) Permit services rendered via telehealth to be reimbursed in compliance with COMAR 10.09.49 Telehealth Services; and

(3) Replace outdated term 'recipient' with 'participant' throughout the chapter.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

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

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Jourdan Green, Director, Office of Regulation and Policy Coordination, Maryland Department of Health, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499, or email to mdh.regs@maryland.gov. Comments will be accepted through February 13, 2023. A public hearing has not been scheduled.

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1)—(7) (text unchanged)

(8) "Participant" means an individual who is certified as eligible for and is receiving Medical Assistance benefits.

[(8)**]** *(9)* "Patient" means a **[**recipient**]** *participant* awaiting or undergoing health care or treatment.

[(9)**]** *(10)*—**[**(11)**]** *(12)* (text unchanged)

[(12) "Recipient" means an individual who is certified as eligible for, and is receiving, Medical Assistance benefits.**]**

(13) (text unchanged)

.03 Conditions for Participation.

A. The general requirements for participation in the Program are that a provider shall **[**meet all conditions for participation as set forth in COMAR 10.09.36.03.**]***:*

(1) Meet all the conditions for participation as set forth in COMAR 10.09.36; and

(2) If delivering services via telehealth, comply with COMAR 10.09.49 and any subregulatory guidance issued by the Department.

B. The specific requirements for participation in the Program as a free-standing urgent care center include the following:

(1)—(3) (text unchanged)

(4) During the hours of operation, have **[**at**]***:*

(a) A supervising physician, available for consultation either in-person or via telehealth; and

(b) At least one qualified physician, *certified nurse practitioner, or physician assistant* present;

(5) Maintain adequate documentation of each **[**recipient**]** *participant* visit as part of the individual's medical record, which, at a minimum, shall include:

(a) (text unchanged)

(b) **[**Recipient's**]** *Participant's* reason for visit;

(c)—(d) (text unchanged)

(6)—(7) (text unchanged)

.04 Covered Services.

The Program covers the following medically necessary services rendered to **[**recipients**]** *participants* in a free-standing urgent care center:

A.—B. (text unchanged)

C. Diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative services, when clearly related to the **[**recipient's**]** *participant's* individual needs;

D.—E. (text unchanged)

.05 Limitations.

The Program does not cover the following:

A.—C. (text unchanged)

D. **[**Services which do not involve direct patient contact (face-to-face)**]** *Services rendered via telehealth that do not comply with the telehealth requirements established in COMAR 10.09.49 and any other subregulatory guidance issued by the Department*;

E.—I. (text unchanged)

.06 Payment Procedures.

A.—H. (text unchanged)

I. The Program may not make a direct payment to a **[**recipient**]** *participant*.

J. (text unchanged)

.07 Recovery and Reimbursement.

A. If the **[**recipient**]** *participant* has insurance, or other coverage, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the **[**recipient**]** *participant* for, services covered by this chapter, the provider shall seek payment from that source first. If an insurance carrier rejects the claim or pays less than the amount allowed by the Program, the provider may submit a claim to the Program. The provider shall submit a copy of the insurance carrier's notice or remittance advice with the invoice. If payment is made by both the Program and the insurance or other source for the same service, the provider shall refund to the Department, within 60 days of receipt, the amount paid by the Program or the insurance or other source, whichever is less.

B. (text unchanged)

.10 Interpretive Regulation.

Except when the language of a specific regulation indicates intent by the Department to provide reimbursement for covered services to Program **[**recipients**]** *participants* without regard to the availability of federal financial participation, State regulations shall be interpreted in conformity with applicable federal statutes and regulations.

DENNIS R. SCHRADER
Secretary of Health