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 – S. Anthony McCann, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 58
January 12, 2005

TO: Managed Care Organizations

FROM: Susan Tucker, Executive Director
Office of Health Services

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

RE: Emergency and Proposed Amendment to HealthChoice Regulations

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ACTION:
Emergency Regulations
Proposed Regulations

EFFECTIVE DATE:
Requested January 1, 2005 effective date

WRITTEN COMMENTS TO:
Michele Phinney
201 W. Preston St., Rm. 538
Baltimore, MD 21201
Fax (410) 767-6483 or call
(410) 767-6499 or
1-877-4MD-DHMH extension 6483

PROGRAM CONTACT:
James Gardner, Chief
Division of HealthChoice Management and Quality Assurance
(410) 767-1482 or call
1-877-4MD-DHMH extension 1482

COMMENT PERIOD EXPIRES: February 7, 2005

The Maryland Medical Assistance Program is promulgating emergency and proposed amendments to amend:

Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions;

Regulations .04 - .06 under COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment;

Regulations .02, .10,.19, .19-3, .20, .21, .22, and adopt new Regulation .19-1 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations;

Regulation .05 under COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access;

Regulations .01, .03, .07, .12, .15, .24, and .27, and adopt new Regulations .26-1 - .26-2 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits;

Regulation .02 under COMAR 10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers;

Regulation .02 under COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures;

Regulation .05 under COMAR 10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures;

Regulation .02 under COMAR 10.09.74 Maryland Medicaid Managed Care Program: Contribution to Graduate Medical Education Costs; and

Regulation .04 under COMAR 10.09.75 Maryland Medicaid Managed Care Program: Corrective Managed Care.

The proposed amendments will:

(1) Revise regulations to include changes to REM-related definitions;

(2) Clarify that MCOs must notify enrollees of their PCP assignment within 10 days of enrollment notification;

(3) Remove the regulation language that requires a recipient to acquire a new anniversary date for purposes of annual reassignment when the enrollee is reassigned to an MCO within 120 days of disenrollment;

(4) Clarify that if family members are enrolled in different MCOs the adult member of the family can request family members be enrolled in one of the MCOs that the family members are enrolled;

(5) Revise cause for MCO disenrollment to be consistent with policy by adding auto-assignment as a for-cause reason;

(6) Add language requiring MCOs to add enrollee's assigned primary care provider's name and telephone number on enrollee identification card to bring regulations to parity with policy;

(7) Add language to specify criteria for Clinical Trials coverage;

(8) Establish new MCO rates for the time period of January 2005 through December 2005;

(9) Add new language for under age 1 kick payment for very low birth weight (less than or equal to 1500 grams);

(10) Update the references to REM regulations to cite the new reference;

(11) Revise the outpatient mid year adjustment regulation language;

(12) Establish MCO-specific case mix-adjusted rate for HIV/AIDS individuals with Hepatitis C;

(13) Revise MCO Statewide supplemental payment and establish MCO supplemental payment criteria for rural enrollment;

(14) Add language to establish criteria for the MCOs to receive retroactive capitation payment.

(15) Revise the self- referred codes and services description for family planning methods;

(16) Revise FQHC payment system;

(17) Clarify that the stop loss protection is for acute hospital inpatient treatment;

(18) Specify MCO requirements when members choose a non EPSDT certified PCP;

(19) Add language to clarify that MCOs are not obligated to provide non- covered services even if the services are medically necessary;

(20) Add new language to allow MCOs to charge $1 copay for generic drugs and $6 copay for non -emergency use of an emergency room;

(21) Revise the physician and advanced practice nurse specialty care services regulation to clarify that the services provided by a doctor of dental medicine or dental surgery are only covered for enrollees who are younger than 21 years old;

(22) Specify criteria for MCOs providing for a private hospital room, and remove the language regarding private hospital room from limitations;

(23) Specify the long term care facilities and describe the situations when the MCO is responsible for the long term care admission;

(24) Clarify what podiatry services are covered and remove the language from the limitations;

(25) Revise the language for diet and exercise program services in limitation;

(26) Revise the language to clarify when surgery or services for cosmetic purposes are covered and remove the language from limitations to covered benefits;

(27) Remove from the limitations the language regarding non-legend drugs that are already included under 10.09.67.04, Benefits- pharmacy services;

(28) Revise the school based health centers regulations to include physician's assistants as appropriate staff for providing health care services in school-based health centers;

(29) Correct the cross reference to Regulation 10.09.65.15.D(1)(b) in COMAR 10.09.71;

(30) Revise the REM Program name from RECM; and

(31) Revise the enrollment in corrective managed care regulations to remove the regulatory language allowing transfer of corrective managed care status when enrollees change MCOs.

A copy of these proposed amendments as published in the January 7, 2005 issue of the Maryland Register is attached to this transmittal.

Attachment

Impact on Individual with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to J. Michael Hopkins, Executive Director, Maryland Racing Commission, 500 N. Calvert Street, Room 201, Baltimore, Maryland 21202, or e-mail to mhopkins@dllr.state.md.us, or fax to (410) 333-8308, or call (410) 230-6330. These comments must be received on or before April 1, 2005.

Open Meeting

Action on the proposed regulation will be considered by the Racing Commission during a public meeting to be held April 12, 2005, at 11 a.m. in the Commission's Office, 500 N. Calvert Street, Room 201, Baltimore, MD.

.53 Sires Stakes Program.

A. Definitions. In this regulation, the following terms have the meanings indicated:

(1) — (3) (text unchanged)

(4) "Covered by a Maryland stallion" means to be bred [in Maryland] to a Maryland stallion whose offspring meet the eligibility requirements for the Sire Stakes Program as provided under this regulation.

(5) — (6) (text unchanged)

B. (text unchanged)

C. Eligibility for Registration.

(1) A horse may be registered with the Advisory Committee if:

[(1)] *(a)* (text unchanged)

[(2)] *(b)* The Maryland stallion:

[(a)] *(i)* — [(d)] *(iv)* (text unchanged)

(2) If a horse is the product of an embryo/ovum transfer, only a donor mare's first born foal each year, resulting from such a transfer, is eligible under this section.

D. — K. (text unchanged)

L. Declaration Fees.

(1) — (2) (text unchanged)

(3) Declaration fees for races at the following racetracks are:

(a) Rosecroft ..... $[600] *400*;

(b) (text unchanged)

M. — AA. (text unchanged)

J. MICHAEL HOPKINS
Executive Director
Racing Commission

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[05-004-P]

The Secretary of Health and Mental Hygiene proposes to:

(1) amend Regulation .01 under **COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions;**

(2) amend Regulations .04 — .06 under **COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment;**

(3) amend Regulations .02, .10, .19, .19-3, .20, .21, .22, and adopt new Regulation .19-1 under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations;**

(4) amend Regulation .05 under **COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access;**

(5) amend Regulations .01, .03, .07, .12, .15, .24, and .27, and adopt new Regulation .26-1 — .26.2 under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits;**

(6) amend Regulation .02 under **COMAR 10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers;**

(7) amend Regulation .02 under **COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures;**

(8) amend Regulation .05 under **COMAR 10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures;**

(9) amend Regulation .02 under **COMAR 10.09.74 Maryland Medicaid Managed Care Program: Contribution to Graduate Medical Education Costs;** and

(10) amend Regulation .04 under **COMAR 10.09.75 Maryland Medicaid Managed Program: Corrective Managed Care.**

Statement of Purpose

The purposes of this action are to:

(1) Revise regulations to include changes to REM-related definitions;

(2) Clarify that MCOs must notify enrollees of their PCP assignment within 10 days of enrollment notification;

(3) Remove the regulation language that requires a recipient to acquire a new anniversary date for purposes of annual reassignment when the enrollee is reassigned to an MCO within 120 days of disenrollment;

(4) Clarify that, if family members are enrolled in different MCOs, the adult member of the family can request family members be enrolled in one of the MCOs in which family members are enrolled;

(5) Revise cause for MCO disenrollment to be consistent with policy by adding autoassignment as a for-cause reason;

(6) Add language requiring MCOs to add enrollee's assigned primary care provider's name and telephone number on enrollee identification card to bring regulations to parity with policy;

(7) Add language to specify criteria for Clinical Trials coverage;

(8) Establish new MCO rates for the time period of January 2005 through December 2005;

(9) Add new language for under age 1 kick payment for very low birth weight (less than or equal to 1,500 grams);

(10) Update the references to REM regulations to cite the new reference;

(11) Revise the outpatient mid-year adjustment regulation language;

(12) Establish MCO-specific case mix-adjusted rate for HIV/AIDS individuals with Hepatitis C;

(13) Revise MCO Statewide supplemental payment and establish MCO supplemental payment criteria for rural enrollment;

(14) Add language to establish criteria for the MCOs to receive retroactive capitation payment;

(15) Revise the self-referred codes and services description for family planning methods;

(16) Revise FQHC payment system;

(17) Clarify that the stop loss protection is for acute hospital inpatient treatment;

(18) Specify MCO requirements when members choose a non-EPSDT certified PCP;

(19) Add language to clarify that MCOs are not obligated to provide non-covered services even if the services are medically necessary;

(20) Add new language to allow MCOs to charge $1 copay for generic drugs and $6 copay for non-emergency use of an emergency room;

(21) Revise the physician and advanced practice nurse specialty care services regulation to clarify that the services provided by a doctor of dental medicine or dental surgery are only covered for enrollees who are younger than 21 years old;

(22) Specify criteria for MCOs providing for a private hospital room and remove the language regarding private hospital room from limitations;

(23) Specify the long term care facilities and describe the situations when the MCO is responsible for the long term care admission;

(24) Clarify what podiatry services are covered and remove the language from the limitations;

(25) Revise the language for diet and exercise program services in limitation;

(26) Revise the language to clarify when surgery or services for cosmetic purposes are covered and remove the language from limitation to covered benefits;

(27) Remove from the limitations the language regarding non-legend drugs that are already included under COMAR 10.09.67.04;

(28) Revise the school-based health centers regulations to include physician's assistants as appropriate staff for providing health care services in school-based health centers;

(29) Correct the cross reference to COMAR 10.09.65.15D(1)(b) in COMAR 10.09.71;

(30) Revise the REM Program name from RECM; and

(31) Revise the enrollment in corrective managed care regulations to remove the regulatory language allowing transfer of corrective managed care status when enrollees change MCOs.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The rate changes will have a negative economic impact on the Department and a positive impact on the MCOs and their subcontracted providers.

II. Types of Economic Impact.	Revenue (R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency:	(E+)	$92,000,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	
D. On regulated industries or trade groups:	(+)	$92,000,000
E. On other industries or trade groups:	(+)	Unknown
F. Direct and indirect effects on public:	NONE	

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

A The Department's projected January — December 2005 expenditure will increase by 6.6 percent on an MCO base of approximately $1,400,000,000 due to the projected increase in HealthChoice enrollment and the increase in rates paid to the MCOs.

D. There will be a positive impact on the MCOs due to the MCO rate increase.

E. The impact of this increase on the MCO subcontracted providers is unknown.

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 Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, Room 521, 201 West Preston Street, 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 February 7, 2005.

10.09.62 Maryland Medicaid Managed Care Program: Definitions

Authority: Health-General Article, §15-101, Annotated Code of Maryland

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) "AIDS payment category" means one of the two payment categories represented as individual rate cells within the rate table set forth in COMAR 10.09.65.19B(4)(b) to which enrollees with AIDS are assigned pursuant to COMAR 10.09.65.19B(2)(c)(ii).

[(1)] *(1-1)* (text unchanged)

(2) (text unchanged)

(2-1) "Activities of daily living" means, in the context of COMAR 10.09.69, bathing, feeding, toileting, dressing, and ambulation;

(3) — (6) (text unchanged)

[(7) "Adult day care" means, in the context of COMAR 10.09.69, services furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week, in an outpatient setting, and includes:

(a) Health and social services needed to ensure the optimal functioning of the client;

(b) Meals, but not constituting a full nutritional regimen of three meals per day; and

(c) Physical, occupational, and speech therapies indicated in the recipients' plan of care.]

[(8)] *(7)* — [(14)] *(13)* (text unchanged)

[(15) "Behavior management treatment" means, in the context of COMAR 10.09.69, an interdisciplinary approach which incorporates a combination of behavior modification, psychotherapy, and pharmacologic therapy which addresses problems interfering with learning, development, and social relationships.]

[(16)] *(14)* — [(18)] *(16)* (text unchanged)

[(19) Repealed.]

[(19-1)] *(17)* — [(19-3)] *(19)* (text unchanged)

(20) — (22) (text unchanged)

(23) "Case management contractor" means, in the context of COMAR 10.09.69, the Department's designee, or a subcontractor of the designee, which[:

(a) Provides] *provides* case management to participants assigned to it by the Department[; and

(b) Has been delegated the authority by the Department to preauthorize health care services for those participants].

(24) "Case manager" means, in the context of COMAR 10.09.69, the individual who:

(a) — (b) (text unchanged)

(c) [Convenes and conducts the meetings of the multidisciplinary team] *Participates in the meetings of the interdisciplinary team*;

(d) [Oversees] *Is responsible for* the development of [individuals] *an individual's case management* [plans of care] *plan* by the [multidisciplinary] *interdisciplinary* team;

(e) Is responsible for implementing the participant's *case management* plan [of care]; [including preauthorizing or otherwise approving the delivery of health-related services;] and

(f) Is responsible for [identifying any changes in the participant's condition or status which might require an adjustment in the plan of care] *modifying the case management plan when information regarding a change in the participant's condition or status is received.*

(25) (text unchanged)

(25-1) "Certified nursing assistant" means, in the context of COMAR 10.09.69, an individual:

(a) Certified as a certified nursing assistant by the Maryland Board of Nursing; and

(b) Who performs nursing tasks delegated by a registered nurse or licensed practical nurse pursuant to Health Occupations Article, Title 8, Annotated Code of Maryland.

(26) — (27) (text unchanged)

[(28) "Chore services" means, in the context of COMAR 10.09.69, heavy household duties such as washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, and maintaining a clean, sanitary, and safe environment in the home for the participant.]

[(29)] *(28)* — [(30-1)] *(30)* (text unchanged)

(31) (text unchanged)

[(32) "Community supported living arrangement-type services (CSLA)" means, in the context of COMAR 10.09.69, one or more of the following services which are intended to assist eligible individuals, regardless of the nature or severity of their disability, to live independently and successfully in the community by assisting them to perform activities of daily living and enabling them to live in homes of their choice, receive services from providers of their choice, and take into account the use of community resources and natural supports:

(a) Personal assistance;

(b) Supports that enhance the individual's opportunities for community participation and to exercise choice and control over the individual's own life;

(c) Training and habilitation services necessary to assist the individual in achieving and maintaining increased integration, interdependence, and productivity;

(d) 24-hour emergency assistance;

(e) Assistive technology;

(f) Adaptive equipment;

(g) Case management services;

(h) Environmental modifications;

(i) Respite care; and

(j) Other services as approved by the Secretary or the Secretary's designee.

(33) "Companion services" means, in the context of COMAR 10.09.69, nonmedical care, supervision, and socialization provided to a functionally impaired adult, that includes assistance with:

(a) Meal preparation;

(b) Laundry;

(c) Shopping; and

(d) Light houskeeping tasks which are incidental to the care and supervision of the client and provided in accordance with a therapeutic goal in the plan of care.]

[(34)] *(32)* (text unchanged)

[(35) "Convalescent care" means, in the context of COMAR 10.09.69, services provided to an individual who requires bed rest and assistance with the activities of daily living either because the individual:

(a) Was recently discharged from the hospital and this care is essential to assure recovery and avoid medical complications; or

(b) Is pregnant and this care is necessary in order to prevent premature delivery.]

[(36)] *(33)* — [(38)] *(35)* (text unchanged)

[(39) "Crisis intervention services" means, in the context of COMAR 10.09.69, the therapeutic response that provides immediate care or referral for an individual with urgent mental health need.

(40) "Day habilitation" means, in the context of COMAR 10.09.69, assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a nonresidential setting, separate from the home or facility in which the recipient resides.]

[(41)] *(36)* — [(48)] *(43)* (text unchanged)

[(49) "Emergency call system" means, in the context of COMAR 10.09.69, an electronic device, connected to a person's phone, which enables an individual at high risk of institutionalization to secure help in the event of an emergency.]

[(50] *(44)* — [(52)] *(46)* (text unchanged)

[(53) "Enhanced Case Management Program" means, in the context of COMAR 10.09.69, the intervention under the waiver which is responsible for providing intensive case management services needed by a participant through case management contractors.]

[(54)] *(47)* (text unchanged)

[(55) "Environmental accessibility modifications" means, in the context of COMAR 10.09.69, physical adaptations to the home, required by the recipient's plan of care, which:

(a) Are necessary to ensure the health, welfare, and safety of the individual; or

(b) Enable the individual to function with greater independence in the home.]

[(56)] *(48)* — [(73)] *(65)* (text unchanged)

(66) "Hepatitis C" means having one of the following as a primary, secondary, tertiary, or level 4 diagnosis:

(a) 070.41 — Acute or Unspecified Hepatitis C with hepatic coma;

(b) 070.44 — Chronic Hepatitis C with hepatic coma;

(c) 070.51 — Acute or unspecified Hepatitis C without mention of hepatic coma; or

(d) 070.54 — Chronic Hepatitis C without mention of hepatic coma.

(67) "Hepatitis C plan risk factor" means an MCO-specific risk adjustment factor reflecting the level of risk associated with the proportion of the MCO's HIV/AIDS enrollees who also have Hepatitis C.

[(74)] *(68)* (text unchanged)

(69) "Historical diagnostic period" means the time period under consideration for the cumulative chronological determination of an enrollee's Hepatitis C status and ending:

(a) For the initial rate adjustment period, on June 30 of the calendar year before the rate year; or

(b) For the mid-year rate adjustment period, on December 31 of the calendar year before the rate year.

[(75)] *(70)* — [(77)] *(72)* (text unchanged)

(73) "HIV/AIDS enrollee" means an enrollee who is infected with HIV or has AIDS and is assigned to an HIV or AIDS payment category.

(74) "HIV payment category" means one of the four payment categories represented as individual rate cells within the rate tables set forth in COMAR 10.09.65.19B(4)(a) and (b), to which enrollees with HIV are assigned pursuant to COMAR 10.09.65.19B(1)(c)(ii) or (2)(c)(i).

(75) "Home", in the context of COMAR 10.09.69, has the meaning stated in COMAR 10.09.53.

(76) "Home health agency" means, in the context of COMAR 10.09.69, an agency licensed by the Department in accordance with COMAR 10.07.10.

(77) "Home health aide" means, in the context of COMAR 10.09.69, an individual who meets all the conditions of participation specified in:

(a) 42 CFR §484.36; and

(b) Health Occupations Article, Title 8, Annotated Code of Maryland.

(78) (text unchanged)

(79) "Hospital" has the meaning stated in Health-General Article, [§19-301(e)] *§19-301*, Annotated Code of Maryland.

(80) — (85) (text unchanged)

[(86) "In-home infusion therapy" means, in the context of COMAR 10.09.69, the administration of fluids and medication intravenously or subcutaneously and includes the use of appropriate medications, supplies, equipment, and professional health care services.

(87) "In-home parenteral therapy" means, in the context of COMAR 10.09.69, the administration of nutrients intravenously, and includes the use of appropriate formulae, supplies, equipment, and professional health care services.]

[(88)] *(86)* (text unchanged)

(87) "Initial rate adjustment period" has the meaning stated in COMAR 10.09.65.19-4A.

[(88-1)] *(88)* (text unchanged)

(89) (text unchanged)

[(90) "Intensive suctioning" means, in the context of COMAR 10.09.69, suctioning 2 to 3 times per shift.

(91) "Intensive therapy" means, in the context of COMAR 10.09.69, treatment which requires the services of a qualified physical therapist, occupational therapist, respiratory therapist, or speech therapist at least 4 times per week.]

(90) "Interdisciplinary team" means, in the context of COMAR 10.09.69, the group convened and conducted by the case manager, consisting of the case manager and relevant service providers, that established the case management plan under the overall direction and coordination of the case manager and in consultation with the participant and, when applicable, the participant's family.

[(92)] *(91)* — [(102)] *(101)* (text unchanged)

[(103) Repealed.]

[(104)] *(102)* — [(118)] *(116)* (text unchanged)

(117) "Mid-year rate adjustment period" has the meaning stated in COMAR 10.09.65.19-4A.

[(119)] *(118)* — [(122)] *(121)* (text unchanged)

[(123) "Multidisciplinary team" means, in the context of COMAR 10.09.69, the group convened and conducted by the case manager, consisting of the case manager and relevant service providers, that establishes the plan of care under the overall direction and coordination of the case manager and in consultation with the participant and the participant's family.]

[(124)] *(122)* — [(126)] *(124)* (text unchanged)

[(127)] *(125)* Nutritional Counseling.

(a) (text unchanged)

(b) "Nutritional counseling" includes family education [and is] provided by either a licensed dietitian[,] *or* licensed nutritionist[, or a registered nurse].

[(128)] *(126)* — [(139)] *(137)* (text unchanged)

[(140)] *(138)* "Plan of care" means, in the context of COMAR 10.09.69, the document which governs a participant's care management, and which [is]:

(a) Includes the:

(i) Case management assessment report;

(ii) Interdisciplinary plan of care; and

(iii) Case management plan;

[(a)] *(b)* [Composed] *Is composed* of [a comprehensive assessment of] the participant's health status and needs for medical, health-related, housing, and social services including, but not limited to:

(i) (text unchanged)

[(ii) Prognosis,]

[(iii)] *(ii)* — [(vii)] *(vi)* (text unchanged)

[(viii) Recommended] *(vii) Current* service providers,

[(ix) Recommended] *(viii) Assigned* level of care,

[(x)] *(ix)* Diet, [if appropriate,]

[(xi) Care or] *(x) Current* living [environment,] *arrangement, and*

[(xii) Crisis] *(xi) Emergency* plan, if appropriate[,]; and

[(xiii) An explanation of how the services specified in the plan of care are being provided in the lowest cost-appropriate setting without reducing quality of care;

(b) Established by the multidisciplinary team; and

(c) Reviewed within 30 days after approval of the initial plan of care, and every 90 days thereafter, unless the case management contractor or the multidisciplinary team decides that a more frequent review period is appropriate.]

(c) Is established in consultation with the interdisciplinary team.

[(141)] *(139)* — [(142)] *(140)* (text unchanged)

[(143)] *(141)* "Preauthorization" [means], in the context of COMAR 10.09.69, [the approval by the Program through a case management contractor which is required

before services can be reimbursed] *has the meaning stated in COMAR 10.09.53.*

[(144)] *(142)* — [(145)] *(143)* (text unchanged)

[(146) "Prevocational services" means, in the context of COMAR 10.09.69, services aimed at preparing an individual for paid or unpaid employment, but which are not job task oriented, and which include teaching such concepts as:

(a) Compliance;

(b) Attendance;

(c) Task completion;

(d) Problem solving; and

(e) Safety.]

[(147)] *(144)* — [(155)] *(152)* (text unchanged)

(153) "Progress note" means, in the context of COMAR 10.09.69, a signed and dated written notation by the home care nurse, home health aide, or certified nursing assistant which:

(a) Summarizes facts about the care given and the participant's response during a given period of time;

(b) Specifically addresses the established goals of treatment;

(c) Is consistent with the participant's case management plan; and

(d) Is written during the course of care.

[(156)] *(154)* — [(160-1] *(159)* (text unchanged)

[(161)] *(160)* — [(164)] *(163)* (text unchanged)

(164) "Rate adjustment period" has the meaning stated in COMAR 10.09.63.19-4A.

(165) "Rate year" has the meaning stated in COMAR 10.09.65.19-4A.

[(165)] *(166)* — [(166)] *(167)* (text unchanged)

(168) "REM optional services" means, in the context of COMAR 10.09.69, the services which meet the general requirements under Regulation .08 and are listed in Regulations .10 and .11 of that chapter.

[(167)] *(169)* — [(168)] *(170)* (text unchanged)

[(169) "Residential habilitation" means, in the context of COMAR 10.09.69, assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a noninstitutional setting.]

[(170)] *(171)* (text unchanged)

(172) "Residential service agency" means, in the context of COMAR 10.09.69, an agency licensed by the Department in accordance with COMAR 10.07.05.

[(171)] *(173)* "Respite care" means, in the context of COMAR [10.09.69 and] 10.09.70, a service provided on a short-term basis in a community-based setting to assist an indivual's home caregiver to maintain the individual in the home by temporarily freeing the caregiver from the responsibility of supervision.

[(172)] *(174)* — [(177)] *(179)* (text unchanged)

[(178) "Skilled personal care services" means, in the context of COMAR 10.09.69, hands-on care, of both a medical and nonmedical supportive nature, specific to the needs of a medically stable or physically handicapped individual, that includes:

(a) Skilled medical care to the extent permitted by State law; and

(b) Housekeeping activities which are incidental to the performance of the client-based care.

(179) "Social work services" means, in the context of COMAR 10.09.69, clinical assistance delivered by licensed social workers under the scope of their license.]

(180) — (182) (text unchanged)

[(183) "Specialized medical equipment and supplies" means, in the context of COMAR 10.09.69, devices, controls, or appliances which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.]

[(184)] *(183)* — [(187)] *(186)* (text unchanged)

[(188) "Stop loss case management (SLCM)" means the method of health care delivery to enrollees with health care expenses as defined at COMAR 10.09.69.]

[(189)] *(187)* — [(200)] *(198)* (text unchanged)

[(201) "Transportation" means, in the context of COMAR 10.09.69, that service which is provided to transport waiver recipients to or from waiver services or other community services and resources, required by the plan of care.]

[(202)] *(199)* — [(203)] *(200)* (text unchanged)

[(204) "Waiver services provider" means, in the context of COMAR 10.09.69, an entity which meets the conditions for participation as specified in COMAR 10.09.69.04, and which is enrolled in the Program.]

(201) "Waiver-eligible" means an individual who qualifies for enrollment in the Maryland Medicaid Managed Care Program.

(202) "Witness", in the context of COMAR 10.09.69, has the meaning stated in COMAR 10.09.53.

10.69.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment

Authority: Health-General Article, Annotated Code of Maryland

Regulations	Sections
.04	§15-103(b)(16)
.05	§15-103(b)(23)
.06	§15-103(b)[(8)] *(3)*, (23)

.04 Assignment to Primary Care Provider (PCP).

Within 10 days of the [effective date] *notification* of enrollment of a new enrollee [in an MCO] or within 10 days of any event that requires a change in an existing enrollee's PCP, an MCO shall notify the enrollee of the enrollee's PCP assignment, subject to the following:

A. — B. (text unchanged)

.05 Reassignment.

A. — E. (text unchanged)

[F. A Program recipient who is reassigned to an MCO under §D of this regulation shall acquire a new anniversary date for purposes of annual reassignment under §B of this regulation.]

[G.] *F.* (text unchanged)

.06 Disenrollment.

A. Enrollee-Initiated Disenrollment for Cause.

(1) An enrollee may disenroll from an MCO and enroll into another MCO if:

(a) (text unchanged)

(b) The family members are enrolled in different MCOs and the adult enrollee requests that [all] *other* familly members be enrolled in one [MCO] *of the MCOs in which another family member is currently enrolled*;

(c) — (e) (text unchanged)

(f) The enrollee is automatically assigned to an MCO and the enrollee requests to enroll into another MCO as follows:

(i) Only one request during the first year of automatic assignment into an MCO; and

(ii) The enrollee is not hospitalized at the time of the request.

[(f)] *(g)* — [(g)] *(h)* (text unchanged)

(2) — (4) (text unchanged)

B. — F. (text unchanged)

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Health-General Article, Annotated Code of Maryland

Regulations	Sections
.02	§15-103(b)(26)
.10	§15-103(b)(10)
.19, .19-1, and .19-3	§15-103(b)(18)
.20	§15-103(b)(11) & (19)
.21	§15-103(e)
.22	§15-103(b)(18) & (26)

.02 Conditions for Participation.

A. — F. (text unchanged)

G. Health Care Delivery. An MCO shall:

(1) — (2) (text unchanged)

(3) Provide each enrollee within 10 days of notification to the MCO of the enrollee's enrollment with a distinctive, durable, plastic identification card, clearly indicating the bearer to be a member of the MCO and containing, at a minimum:

(a) The enrollee's Medicaid number[,];

(b) The MCO's consumer services hotline telephone number[, and];

(c) The Department's enrollee hotline telephone number; *and*

(d) Enrollee's assigned primary care provider's name and telephone number;

(4) — (5) (text unchanged)

H. — Y. (text unchanged)

.10 Special Needs Populations — Individuals with HIV/AIDS.

A. — E. (text unchanged)

F. *Clinical Trials.*

(1) An MCO may refer enrollees who are individuals with HIV/AIDS to facilities or organizations that can provide the enrollees' access to clinical trials.

(2) An MCO shall provide enrollees with HIV/AIDS access to clinical trials in accordance with COMAR 10.09.67.26-1.

.19 MCO Reimbursement.

A. Generally.

(1) — (6) (text unchanged)

(7) Effective January 1, 2005, the Department may consider a retroactive capitation payment to an MCO, if the MCO notifies the Department within 9 months of the first missed capitation payment for an enrollee for whom the MCO has not received all appropriate capitation payments.

B. Capitation Rate-Setting Methodology.

(1) Families and Children. Capitation rates for enrollees who are waiver-eligible based upon receipt of benefits through TCA or programs for medically needy families and children, including SOBRA children *and Maryland Children's Health Program (MCHP)*, shall be established as follows:

(a) For enrollees *eligible under COMAR 10.09.63.01A(1) or (3), and for children eligible under COMAR 10.09.63.01A(2)* for whom the Department has sufficient clinical data, the Department shall:

(i) — (ii) (text unchanged)

(iii) Assign an enrollee to a risk adjustment category based upon the enrollee's ACG assignment; [and]

(b) [For] *Except as provided in §B(1)(c) of this regulation,* for enrollees for whom the Department has insufficient data to generate an ACG assignment, the Department shall assign the enrollee to a risk adjustment category that reflects the enrollee's [age,]:

(i) *Age*, residence, and gender[.]; *and*

(ii) Birth weight with respect to an enrollee born after December 31, 2004; and

(c) On the basis of the enrollee's residence, the Department shall assign:

(i) All SOBRA mothers enrolled pursuant to COMAR 10.09.63.01A(2) to one of the two "SOBRA mother" payment categories set forth in §B(4)(a) of this regulation; and

(ii) Enrollees with HIV to one of the two HIV payment categories set forth in §B(4)(a) of this regulation.

(2) Disabled. Capitation rates for enrollees who are waiver-eligible based upon receipt of benefits through SSI or as medically needy, aged, blind, or disabled shall be established as follows:

(a) [For] *Except as provided in §B(2)(c) of this regulation, for* enrollees for whom the Department has sufficient clinical data, the Department shall:

(i) — (iii) (text unchanged)

(b) [For] *Except as provided in §B(2)(c) of this regulation, for* enrollees for whom the Department has insufficient data to generate an ACG assignment, the Department shall assign the enrollee to a risk adjustment category that reflects the enrollee's age, residence, and gender[.]; *and*

(c) On the basis of the enrollee's residence, the Department shall assign:

(i) Enrollees with HIV to one of the two HIV payment categories set forth in §B(4)(b) of this regulation; and

(ii) Enrollees with AIDS to one of the two AIDS payment categories set forth in §B(4)(b) of this regulation.

(3) [Capitation] Rate Setting Methodology for [Special Payment Categories.

(a) Unless §B(3)(b) of this regulation applies] *Supplemental Delivery/Newborn Payments. In addition to the monthly payment specified in §B(4)(a) or (b) of this regulation for an enrollee's payment category* the Department shall pay an MCO [a single] *one* supplemental payment [for maternity delivery and newborn costs for enrollees who are waiver-eligible] *per pregnancy in the amount specified in §B(4)(c) of this regulation, upon delivery of one or more live infants without regard to method, timing, or place of delivery.*

[(b) The Department shall pay a monthly payment for PWC (SOBRA) mothers, supplemented by the single maternity and newborn payment after the delivery of the child.]

(4) [The] *Except to the extent of adjustments required by §D of this regulation, or by Regulations .19-1 — .19-4 of this chapter, the* Department shall make [capitation] payments monthly at the rates specified in the following tables:

(a) — (b) (proposed for repeal)

(a) Rate Table for Families and Children.

Effective January 1, 2005 — December 31, 2005.

	Age	Gender	PMPM Baltimore City	PMPM Rest of State
Demographic Cells	Born in CY 05		$3,786.45	$3,382.66
	Birth weight 1500 grams or less	Both		
	Born in CY 05		$ 341.76	$ 328.56
	Birth weight over 1500 grams	Both		
	Under Age 1	Both	$ 280.51	$ 220.94
	Born before CY 05	Male	$ 162.67	$ 127.55
	1 — 5	Female	$ 145.08	$ 113.75
	6 — 14	Male	$ 95.06	$ 74.54
		Female	$ 85.27	$ 66.86
	15 — 20	Male	$ 112.36	$ 88.09
		Female	$ 191.22	$ 149.93
	21 — 44	Male	$ 338.04	$ 265.05
		Female	$ 331.42	$ 259.85
	45 — 64	Male	$ 893.99	$ 700.95
		Female	$ 702.50	$ 550.81
ACG-adjusted cells				
ACG 100, 200, 300, 500, 600, 1100, 1600, 2000, 2400, 3400, 5110, 5200	RAC1	Both	$ 79.21	$ 67.95
ACG 400, 700, 900, 1000, 1200, 1300, 1710, 1800, 1900, 2100, 2200, 2300, 2800, 2900, 3000, 3100, 5310	RAC2	Both	$ 106.05	$ 90.97
ACG 1720, 1730, 2500, 3200, 3300, 3500, 3800, 4210, 5320, 5339	RAC3	Both	$ 134.80	$ 115.63
ACG 800, 1740, 1750, 2700, 3600, 3700, 3900, 4000, 4100, 4220, 4310, 4410, 4510, 4610, 4710, 4720, 4810, 5340	RAC4	Both	$ 218.22	$ 187.20
ACG 1400, 1500, 1760, 1770, 2600, 4320, 4520, 4620, 4820	RAC5	Both	$ 295.99	$ 253.91
ACG 4330, 4420, 4830, 4910, 4920, 5010, 5020, 5040	RAC6	Both	$ 488.23	$ 418.81
ACG 4430, 4730, 4930, 5030, 5050	RAC7	Both	$ 630.33	$ 540.71
ACG 4940, 5060	RAC8	Both	$ 971.39	$ 833.28
ACG 5070	RAC9	Both	$1,200.61	$1,029.91
SOBRA Mothers			$ 569.53	$ 446.55
Persons with HIV	All	Both	$ 690.00	$ 690.00

(b) Rate Table for Disabled Individuals, January 1, 2005 — December 31, 2005.

Demographic Cells	Under Age 1	Both	$1,812.95	$1,812.95
	1 — 5	Male	$ 625.02	$ 625.02
		Female	$ 665.98	$ 665.98
	6 — 14	Male	$ 134.23	$ 134.23
		Female	$ 247.56	$ 247.56

	Age	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
Demographic Cells	*15 — 20*	*Male*	*$ 317.23*	*$ 317.23*
		Female	*$ 366.04*	*$ 366.04*
	21 — 44	*Male*	*$1,123.39*	*$ 880.82*
		Female	*$1,041.76*	*$ 816.81*
	45 — 64	*Male*	*$1,464.70*	*$1,148.43*
		Female	*$1,394.60*	*$1,093.47*
ACG — adjusted cells				
ACG 100, 200, 300, 1100, 1300, 1400, 1500, 1600, 1710, 1720, 1730, 1900, 2400, 2600, 2900, 3400, 5110, 5200, 5310	*RAC10*	*Both*	*$ 215.05*	*$ 184.47*
ACG 400, 500, 700, 900, 1000, 1200, 1740, 1750, 1800, 2000, 2100, 2200, 2300, 2500, 2700, 2800, 3000, 3100, 3200, 3300, 3500, 3900, 4000, 4310, 5330	*RAC11*	*Both*	*$ 325.10*	*$ 278.88*
ACG 600, 1760, 3600, 3700, 4100, 4320, 4410, 4710, 4810, 4820	*RAC12*	*Both*	*$ 576.63*	*$ 494.65*
ACG 3800, 4210, 4220, 4330, 4420, 4720, 4910, 5320	*RAC13*	*Both*	*$ 696.28*	*$ 597.28*
ACG 800, 4430, 4510, 4610, 5040, 5340	*RAC14*	*Both*	*$ 888.81*	*$ 762.44*
ACG 1770, 4520, 4620, 4830, 4920, 5050	*RAC15*	*Both*	*$1,024.23*	*$ 878.60*
AGC 4730, 4930, 5010	*RAC16*	*Both*	*$1,296.07*	*$1,111.79*
ACG 4940, 5020, 5060	*RAC17*	*Both*	*$1,759.23*	*$1,509.10*
ACG 5030, 5070	*RAC18*	*Both*	*$2,331.45*	*$1.999.97*
Persons with AIDS	*All*	*Both*	*$3,158.90*	*$2,651.24*
Persons with HIV	*All*	*Both*	*$1,820.83*	*$1,820.83*

(c) Rate Table for Supplemental Payment for Delivery/Newborn. Effective January 1, 2005 — December 31, 2005.

Supplemental Payment Cells	Age/RAC	Gender	Baltimore City	Rest of State
Delivery/Newborn — live birth weight over 1,500 grams	All	Both	$11,100.62	$8,533.76
Delivery/Newborn — live birth weight 1,500 grams or less	All	Both	$79,039.92	$55,852.39

[(c)] *(d)* Interpretation of Rate Table for Families and Children. The table found at §B(4)(a) of this regulation shows capitation rates for individuals who are [waiver-eligible]*;*

(i) Waiver eligible based on receipt of benefits through TCA or programs for medically needy families and children[*, including*]*;*

(ii) SOBRA children[.]*;*

(iii) SOBRA mothers; and

(iv) The Maryland Children's Health Program.

[(d)] *(e)* (text unchanged)

(f) Interpretation of Rate Table for Supplemental Payment for Delivery/Newborn. The table found at §B(4)(c) of this regulation shows a supplemental payment made in connection with deliveries of MCO enrollees, regardless of the enrollee's payment category under COMAR 10.09.65.19B(4)(a) or (b).

[(e)] *(g)* (text unchanged)

(5) (text unchanged)

C. (text unchanged)

D. Interim Rates Adjustments.

(1) (text unchanged)

(2) The Department shall adjust the [capitation] *payment* rates specified in [§B(4)(a) and (b)] *§B(4)(a) — (c)* of this regulation to reflect service cost changes that qualify under §D(3) of this regulation and result from:

(a) (text unchanged)

(b) An increase or decrease in Medicaid fee-for-service payment rates or copayments, if the MCOs are obligated to adjust their payment rates to providers as a result of those fee-for-service rate changes; [or]

(c) An increase or decrease in statewide hospital charge-per-case as approved by the Health Services Cost Review Commission[.]*; or*

(d) An increase or decrease in the statewide hospital outpatient rate update factor as approved by the Health Services Cost Review Commission.

(3) — (8) (text unchanged)

.19-1 MCO-Specific Case Mix Adjustment for HIV and AIDS with Hepatitis C.

A. To reflect the higher level of risk associated with providing covered health care services pursuant to COMAR 10.09.67 to HIV/AIDS enrollees who also have Hepatitis C, the Department shall, to the extent provided by this regulation, make MCO-specific adjustments to payments for enrollees in HIV and AIDS payment categories to reflect the proportion of an MCO's HIV/AIDS enrollees who also have Hepatitis C.

B. Identification of HIV/AIDS Enrollees with Hepatitis C.

(1) For each MCO, the Department shall consider historical encounter and fee-for-service data for enrollees assigned to HIV and AIDS payment categories:

(a) For the initial assessment period, as of June of the calendar year before the rate year; and

(b) For the mid-year assessment period, as of December of the calendar year before the rate year.

(2) For each MCO, the Department shall determine which of the HIV/AIDS enrollees meeting the criteria set forth in §B(1) of this regulation also have Hepatitis C.

(3) The Department shall use encounter and fee-for-service data documenting services provided to the HIV/AIDS enrollees identified in accordance with §B(1) of this regulation for the appropriate historical diagnostic period:

(a) For the initial assessment period, through June of the calendar year before the rate year; and

(b) For the mid-year assessment period, through December of the calendar year before the rate year.

C. Methodology for Determining MCO-specific HIV and AIDS Case Mix Measures. For each MCO, the Department shall:

(1) Based on encounter and fee-for-service data from the appropriate historical diagnostic period, classify the MCO's HIV/AIDS enrollees identified pursuant to §B of this regulation as either:

(a) Hepatitis C-infected; or

(b) Hepatitis C-uninfected.

(2) Average relative value for HIV and AIDS payment categories are as follows:

(a) Apply weights reflecting costs associated with Hepatitis C-infected and Hepatitis C-uninfected enrollees in each HIV and AIDS payment category to the MCO-specific distribution of HIV/AIDS enrollees who are Hepatitis C-infected or Hepatitis C-uninfected, as determined pursuant to §C(1) of this regulation; and

(b) For each MCO, use the results of the calculations specified in §C(2)(a) of this regulation to separately calculate an average relative value for each of the HIV and AIDS payment categories.

(3) To determine an MCO's relative case mix factors, each MCO's relative values determined pursuant to §C(2)(b) of this regulation are divided by the overall average relative value determined pursuant to §C(2)(a) of this regulation.

D. Methodology for MCO-Specific Case Mix-Adjusted HIV and AIDS Rates. For each MCO, the Department shall:

(1) Calculate MCO-specific HIV and AIDS relative case mix factors for each HIV and AIDS payment group pursuant to §C(3) of this regulation;

(2) Calculate MCO-specific HIV and AIDS rates for the rate adjustment period by multiplying the risk adjustment factor derived pursuant to §D(1) of this regulation by the value specified for each HIV and AIDS payment group for the rate year; and

(3) Apply a budget neutrality adjustment to the values derived pursuant to §D(2) of this regulation so that the aggregate of payments to all MCOs pursuant to this regulation are equivalent to the aggregate of all payments that would be due to all MCOs in the absence of this regulation.

E. Case Mix Updates. The Department shall:

(1) Update current enrollees' region of residence and enrollment categories by repeating the calculations in §§B — D of this regulation every 6 months using residence and enrollment data as of the enrollment month specified below:

(a) For the initial assessment period of each rate year, June of the calendar year before the rate year; and

(b) For the mid-year assessment period of each rate year, December of the calendar year before the rate year; and

(2) For rate adjustment periods beginning January 1 and July 1 of each rate year, use each MCO's updated Hepatitis C-infected and Hepatitis C-uninfected distribution to compute its risk adjusted HIV and AIDS payment rates for each rate adjustment period, as described in §D of this regulation.

.19-3 MCO Statewide *and Rural* Supplemental [Payment] *Payments*.

A. *Statewide Supplemental Payment.*

(1) On the payment dates specified in [*§B*] *§A(2)* of this regulation, the Department shall make a Statewide supplemental payment to any MCO that has been approved for participation and has decided to operate without restricted enrollment in all local access areas within at least 20 of the 24 State jurisdictions.

[B.] *(2)* MCOs are eligible to receive a *Statewide* supplemental payment or payments if the following conditions are met:

[(1)] *(a) For* June [2004] *2005* payment:

[(a)] *(i)* (text unchanged)

[(b)] *(ii)* The qualifications *set forth* in [§A] *§A(1)* of this regulation were met from January 1 through June 30, [2004] *2005*; and

[(2)] *(b) For* December [2004] *2005* payments:

[(a)] *(i)* (text unchanged)

(b) *(ii)* The qualifications *set forth* in [§A] *§A(1)* of this regulation were met from July 1 through December 31, [2004] *2005*.

[C.] *(3) Amount of Statewide Supplemental Payments.*

(a) The June [*2004*] *2005* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in May [*2004*] *2005* prospectively for that MCO's June [*2004*] *2005* enrollment, multiplied by [$10.21] *$5.11* per enrollee.

[D.] *(b)* The December [2004] *2005* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in November [2004] *2005* prospectively for that MCO's December [2004] *2005* enrollment, multiplied by [$10.21] *$5.11* per enrollee.

B. Supplemental Payment for Rural Enrollment.

(1) In addition to the Statewide supplemental payment authorized by §A of this regulation, the Department shall make a supplemental payment or payments reflecting the number of an MCO's enrollees living in one of the counties specified in §B(4) of this regulation.

(2) To qualify for a supplemental payment for rural enrollment, an MCO shall qualify, for the same time period as specified in §A(2) of this regulation, for a Statewide supplemental payment pursuant to §A of this regulation.

(3) Amount of Rural Enrollment Supplement Payment.

(a) For the June 2005 payments to MCOs meeting the requirements specified in §A of this regulation from January 1 through June 30, 2005, the Department shall pay an amount equal to the total number of that MCO's enrollees in counties specified in §B(4) of this regulation and paid for in May 2005 prospectively for that MCO's June 2005 enrollment, multiplied by $22.99 per enrollee.

(b) For the December 2005 payments to MCOs meeting the requirements specified in §A of this regulation from July 1 through December 31, 2005, the Department shall pay each qualifying MCO an amount equal to the total number of that MCO's enrollees in counties specified in §B(4) of this regulation and paid for in November 2005 prospectively for that MCO's December 2005 enrollment, multiplied by $22.99 per enrollee.

(4) Rural Enrollment Counties. For purposes of this regulation, the following counties are rural enrollment areas:

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

.20 MCO Payment for Self-Referred, Emergency, and Physician Services.

A. MCO Payment for Self-Referred Services.

(1) (text unchanged)

(2) An MCO shall reimburse out-of-plan providers to whom enrollees have self-referred for school-based services and family planning services specified in the table below at the established Medicaid rates for the services or devices indicated:

CPT code	Service Description
99201	Office visit, new patient, minimal
99202	Office visit, new patient, moderate
99203	Office visit, new patient, extended
99204	Office visit, new patient, comprehensive
99205	Office visit, new patient, complicated
99211	Office visit, established patient, minimal
99212	Office visit, established patient, moderate
99213	Office visit, established patient, extended
99214	Office visit, established patient, comprehensive
99215	Office visit, established patient, complicated
57170	Diaphragm fitting with instructions
58300	Insert intrauterine device
58301	Remove intrauterine device
99070	Special contraceptive supplies *including but not limited to Ortho-Evra Patch*
A4260	Norplant contraceptive
A4261	*Cervical Cap*
A4266	*Diaphragm*
11975	Insert contraceptive capsules
11976	Remove contraceptive capsules
11977	Removal with reinsertion of capsules
J1055	Depo-Provera-FP
00997	Latex condoms
J1056	Lunelle
J7302	Mirena
J7300	IUD[-Copper] *Kit*
J7303	*Contraceptive Vaginal Ring*

(3) — (9) (text unchanged)

B. — C. (text unchanged)

.21 Payments to Federally Qualified Health Centers (FQHC).

A. For any FQHC that has agreed to be reimbursed under the Alternative Payment System (APS) for dates of service on or after January 1, 2005:

(1) The Department shall:

(a) Pay the MCO a prospective payment based on encounter data; and

(b) Reconcile the prospective amount paid to the MCO with the MCO's actual expenditure amount, after receipt of MCO encounter data; and

(2) The MCO shall reimburse any contracted FQHC, the FQHC's rate established in accordance with COMAR 10.09.08.05-1A.

B. For any FQHC choosing not to participate in the APS for dates of service on or after January 1, 2005, the MCO shall reimburse the contracted FQHC as follows:

[A.] *(1)* Effective January 1, [2004], *2005*, an MCO shall reimburse an FQHC with which it subcontracts at least [$63.11] *$64.66* per visit for Medicaid covered services other than dental services.

[B.] *(2)* Effective January 1, [2004], *2005*, an MCO shall reimburse an FQHC with which it subcontracts at least [$16.28] *$16.92* per visit for dental services to recipients younger than 21 years old and to pregnant women.

[C.] *(3)* (text unchanged)

[D.] *(4)* The Department shall reimburse each FQHC on a monthly basis a supplemental payment equaling the difference between the rate specified in [§§A and B] *§B(1) and (2)* of this regulation and each FQHC's corresponding per visit rate established in accordance with COMAR [10.09.08.05E] *10.09.08.05-1A* for Medicaid-covered FQHC services.

[E.] *(5)* (text unchanged)

C. For self-referred services described in Regulation .20 of this chapter, the MCO shall pay the FQHC's usual rate in accordance with §§A and B of this regulation, regardless of the FQHC's contracted status with the MCO.

.22 Stop Loss Program.

A. (text unchanged)

B. An MCO shall notify the Department that the *acute* inpatient hospital costs of an enrollee are expected to exceed the Stop Loss limit as soon as it knows that this is likely to occur.

C. Upon confirming eligibility for stop loss protection, the Department shall assume liability for reimbursement of 90 percent of accrued *acute* inpatient hospital charges according to established Medicaid fee-for-service rates for medically necessary and appropriate [hospital] *acute* inpatient treatment rendered to the enrollee above the stop loss limit throughout the remainder of the calendar year.

D. An MCO shall remain financially liable for reimbursing 10 percent of accrued *acute* inpatient hospital charges for medically necessary and appropriate [hospital inpa-

tient] treatment rendered to the enrollee above the stop loss limit throughout the remainder of the calendar year, and shall maintain full responsibility for the provision of health care services to the enrollee.

E. (text unchanged)

F. The Department's Extended Stop Loss Period.

(1) If an inpatient enrollee remains hospitalized at the end of a calendar year and incurs *acute* hospital costs that exceed the Stop Loss limit into the following calendar year without interruption, the Department's stop loss period shall be extended until the end of that hospitalization.

(2) The MCO shall remain financially liable for costs up to the Stop Loss limit for enrollees who remain hospitalized *in an acute setting* at the end of the calendar year as specified in §§A and D of this regulation until the enrollee is discharged.

G. — I. (text unchanged)

10.09.66 Maryland Medicaid Managed Care Program: Access

Authority: Health-General Article, §15-103(b)(9)(iii), (v), Annotated Code of Maryland

.05 Access Standards: PCPs and MCO's Provider Network.

A. Primary Care Provider (PCP).

(1) — (3) (text unchanged)

(4) If the enrollee's parent, guardian, or caretaker, as appropriate, chooses a non-EPSDT certified PCP in accordance to §A(3) of this regulation, within 30 days of enrollment, the MCO shall:

(a) Notify the parent, guardian, or caretaker, by letter, that a non-EPSDT certified PCP has been chosen; and

(b) Include in the notification, with a copy to the Department, an explanation of the:

(i) EPSDT preventive screening services to which an enrollee is entitled according to the EPSDT periodicity schedule;

(ii) Importance of accessing the EPSDT preventive screening services; and

(iii) Process for requesting a change to an EPSDT-certified PCP to obtain preventive screening services.

[(4)] *(5)* — [(5)] *(6)* (text unchanged)

B. (text unchanged)

10.09.67 Maryland Medicaid Managed Care Program: Benefits

Authority: Health-General Article, Annotated Code of Maryland

Regulations	Sections
.01, .03	§15-103(b)(2)(i)
.07, .12	§15-103(b)(2)
.15	§15-103(b)(2)(i)
.24 — .33	§15-103(b)(2)(i), (b)(9)(iii)

.01 Required Benefits Package — In General.

A. Except [as provided] *for non-covered services set forth* in Regulation .27 of this chapter, an MCO shall provide its enrollees with a benefits package that includes [at least] the *covered* services specified in this chapter [that are] *when these services are* deemed to be medically necessary and, *for adults, medically* appropriate.

B. An MCO is not required to provide non-covered services even when the service is medically necessary.

[B.] *C.* (text unchanged)

[C.] *D.* Cost Sharing and Prohibitions.

(1) Except for the following, an MCO may not charge its enrollees any copayments, premiums, or cost sharing:

(a) Up to a $2 copayment for brand-name drugs; [or]

(b) Up to $1 copayment for generic drugs;

(c) Up to a $6 copayment for non-emergency use of an emergency room; or

[(b)] *(d)* (text unchanged)

(2) (text unchanged)

[D.] *E.* Interpretation. This chapter is intended to describe a baseline benefits package for MCOs that is equivalent to Medicaid benefits available as of January 1, 1996, under Maryland's Medicaid fee-for-service system, except as follows:

(1) Regulation .27B(5) — (12), (27), (29), and [(38)] *(36)* of this chapter excludes from the MCO's baseline benefits package, certain services that were covered under the Medicaid fee-for-service program, but are not the MCO's responsibility in the Maryland Medicaid Managed Care Program; and

(2) (text unchanged)

[E.] *F.* (text unchanged)

.03 Benefits — Physician and Advanced Practice Nurse Specialty Care Services.

A. An MCO shall provide to its enrollees medically necessary and appropriate specialty care services that are outside of the enrollee's PCP's scope of practice, or, in the judgment of the enrollee's PCP, are not services that the PCP customarily provides, is specifically trained for, or is experienced in and are provided by:

(1) — (3) (text unchanged)

(4) [A] *For enrollees who are younger than 21 years old, a* doctor of dental medicine or dental surgery, if the services are surgical services that are also typically performed by physicians.

B. (text unchanged)

.07 Benefits — Inpatient Hospital Services.

A. — F. (text unchanged)

G. An MCO shall provide for a private hospital room when:

(1) The enrollee's condition requires a need for isolation; or

(2) The enrollee requires admission and only private rooms are available.

.12 Benefits — [Nursing] *Long-Term Care* Facility Services.

A. An MCO shall provide to its enrollees medically necessary and appropriate *services in a chronic hospital, a rehabilitation hospital, or a* nursing facility [services] for:

(1) — (2) (text unchanged)

B. — F. (text unchanged)

.15 Benefits — Podiatry Services.

An MCO shall provide for its enrollees medically necessary and appropriate podiatry services[.] *as follows:*

A. Medically necessary services for enrollees younger than 21 years old;

B. Diabetes care services specified in COMAR 10.09.67.24; and

C. Routine foot care for enrollees, 21 years old or older with vascular disease affecting the lower extremities.

.24 Benefits — Diabetes Care Services.

A. — B. (text unchanged)

C. In addition to the services included in its usual benefits package, an MCO shall provide, at least to the enroll-

ees who qualify under §B of this regulation, the following medically necessary and appropriate special diabetes-related services:

(1) (text unchanged)

(2) Diabetes outpatient education; [and]

(3) Diabetes-related durable medical equipment, disposable medical supplies, and therapeutic footwear and related services, when ordered as medically necessary and appropriate, including:

(a) Therapeutic footwear, *orthopedic shoes, arch supports, orthotic devices, in-shoe supports, elastic support, or examinations for prescription or fitting* and related services to prevent or delay a foot amputation that would be highly probable in the absence of the specialized footwear[,];

(b) Blood glucose monitoring supplies[,];

(c) Diagnostic reagent strips and tablets used in testing for ketones and glucose in urine and glucose in blood[,];

(d) Finger-sticking devices used in obtaining blood samples for blood glucose testing[,]; and

(e) Blood glucose reflectance meters for home use[.]; *and*

(4) Routine foot care.

.26-1 Clinical Trial Items and Services — Coverage for Routine Costs.

A. Subject to the conditions specified in §§B — F of this regulation, an MCO shall provide coverage for cost to an enrollee in an approved clinical trial for:

(1) Treatment provided for life-threatening conditions; or

(2) Prevention, early detection, and treatment studies on cancer.

B. Clinical trials are deemed to be automatically approved if:

(1) The treatment is:

(a) Being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trials for cancer; or

(b) Being provided in Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition;

(2) The treatment is being provided in a clinical trial:

(a) Approved by:

(i) The National Institutes of Health (NIH);

(ii) An NIH cooperative group or an NIH center;

(iii) The Centers for Disease Control and Prevention;

(iv) The Agency for Healthcare Research and Quality;

(v) The Centers for Medicare and Medicaid Services (CMS);

(vi) The Department of Defense;

(vii) The Department of Veterans Affairs; or

(viii) An institutional review board of an institution in the State that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH; or

(b) Conducted:

(i) At National Cancer Institute Centers;

(ii) Under Investigational New Drug application (IND) reviewed by the Food and Drug Administration (FDA); or

(iii) As a clinical trial with deemed status through an exemption from having an IND under 21 CFR §312.2(b)(1);

(3) The facility and the personnel providing the treatment are capable of doing so by virtue of the facility and the personnel's experience, training, and volume of patients treated to maintain expertise;

(4) There is no clearly superior, non-investigational treatment alternative; and

(5) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

C. Enrollee cost includes the following:

(1) The cost of all medically necessary items and services that are otherwise available to Medicaid beneficiaries such as hospital services, physician services, or diagnostic tests; and

(2) The cost of medically necessary items or services required solely for the provision of the following:

(a) Investigational item or service such as administration of a noncovered chemotherapeutic agent;

(b) The clinically appropriate monitoring of the effects of the item or service; or

(c) The prevention, diagnosis, and treatment of complications.

D. Enrollee cost does not include the following:

(1) The cost of the investigational item or service itself;

(2) The cost of items and services provided solely to satisfy data collectioin and analysis needs and that are not used in the direct clinical management of the enrollee;

(3) The cost of items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

(4) The cost of non-health care services that an enrollee may be required to receive as a result of the treatment being provided for purposes of the clinical trial.

E. If the enrollee has insurance or other coverage, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the enrollee for, services covered by this regulation, the provider shall seek payment from that source first.

F. The MCO shall authorize the request for participation in an approved clinical trial within 5 working days of the request.

.26-2 Plastic and Restorative Surgery.

An MCO shall provide to an enrollee medically necessary surgery to correct a deformity from disease, trauma, congenital or developmental anomalies, or to restore body functions.

.27 Benefits — Limitations.

A. (text unchanged)

B. The benefits or services not required to be provided under §A of this regulation are as follows:

(1) Experimental or investigational services, including organ transplants determined by Medicare to be experimental, *except when an enrollee is participating in an authorized clinical trial as specified in Regulation .26-1 of this chapter;*

(2) — (16) (text unchanged)

(17) Diet and exercise programs for the loss of weight [except when medically necessary and appropriate];

(18) — (20) (text unchanged)

[(21) Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;]

[(22)] *(21)* — [(23)] *(22)* (text unchanged)

[(24) Private hospital room, unless medically necessary;]

[(25)] *(23)* — [(29)] *(27)* (text unchanged)

[(30) Arch supports, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or examinations for their

prescription or fitting, except when the enrollee qualifies for diabetes care services under Regulation .24 of this chapter or is younger than 21 years old;

(31) Routine foot care, except for visits for continued or chronic podiatric care for enrollees who are diabetic or who have a vascular disease affecting the lower extremities or are younger than 21 years old;

(32) Non-legend drugs other than insulin and enteric coated aspirin for the treatment of arthritic conditions;**]**

[(33)**]** *(28)* — **[**(41)**]** *(36)* (text unchanged)

10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers

Authority: Health-General Article, §15-103(b)(19)(i), Annotated Code of Maryland

.02 Designation as a School-Based Health Center.

A. On application to the Department, a provider that is located on school grounds may be designated as a school-based health center if it demonstrates that it meets the following criteria:

(1) — (7) (text unchanged)

(8) Maintains a staffing pattern that includes at least one advanced practice nurse in a practice category listed in COMAR **[**10.09.66.05A(3)(f) or (g), or**]** *10.09.66.05A(4)(f) or (g)*, a physician, *or a physician's assistant* on site whenever comprehensive primary health care services are being delivered;

(9) — (12) (text unchanged)

B. (text unchanged)

10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures

Authority: Health-General Article, §15-103(b)(i)(4), Annotated Code of Maryland

.02 Internal Grievance Process for Enrollees.

A. — B. (text unchanged)

C. An MCO shall include in the internal grievance process described in the written grievance procedures the procedures for registering and responding to complaints in a timely fashion, which:

(1) — (9) (text unchanged)

(10) Include a documented procedure for reporting of all:

(a) Complaints received by the MCO to:

(i) — (iii) (text unchanged)

(iv) The Department as requested; and

(b) The quarterly complaint analysis performed by the MCO as specified in COMAR **[**10.09.65D(1)(a)(ii)**]** *10.09.65D(1)(b)*; and

(11) (text unchanged)

10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures

Authority: Health-General Article, **[**Title 15, Subtitle 1**]** *§15-103(b)(9)(i)(4)*, Annotated Code of Maryland

.05 Enrollee Appeal.

A. (text unchanged)

B. A waiver-eligible individual may appeal a Department decision:

(1) — (2) (text unchanged)

(3) Transferring a waiver-eligible individual to the **[**RECM**]** *REM* program.

C. — E. (text unchanged)

10.09.74 Maryland Medicaid Managed Care Program: Contribution to Graduate Medical Education Costs

Authority: Health-General Article, §15-103(b)(18), Annotated Code of Maryland

.02 GME Allocation Payment.

A. (text unchanged)

B. GME Allocationi Payments to Teaching Hospitals. Beginning in FY 1999, the Department shall, on a quarterly basis, pay each teaching hospital a GME allocation payment, calculated as follows:

(1) The Department shall calculate the combined dollar amount of payments made by the Program to teaching hospitals during FY 1995, including only those payments attributable to utilization:

(a) (text unchanged)

(b) By recipients who, if the utilization had occurred during the fiscal year in which the GME allocation payment is made:

(i) (text unchanged)

(ii) Would not have met the eligibility criteria for the rare and expensive case management program, pursuant to COMAR **[**10.09.69.01.**]** *10.09.69.03*;

(2) — (6) (text unchanged)

10.09.75 Maryland Medicaid Managed Care Program — Corrective Managed Care.

Authority: Health-General Article, §§15-102.3(b)(9) and 15-103, Annotated Code of Maryland

.04 Enrollment in Corrective Managed Care.

A. — C. (text unchanged)

[D. Annual Right to Change.

(1) An enrollee who is enrolled in corrective managed care may select another MCO in accordance with COMAR 10.09.63.05 and .06A.

(2) An enrollee's new MCO may continue to place the enrollee in corrective managed care according to the time frame already established by the previous MCO and in accordance to §C of this regulation.**]**

[E.**]** *D.* (text unchanged)

S. ANTHONY McCANN
Secretary of Health and Mental Hygiene

Subtitle 24 MARYLAND HEALTH CARE COMMISSION

10.24.01 [Determination of] Certificate of Need for Health Care Facilities

Authority: Health-General Article, §§19-109(a)(1), 19-114(e), 19-120, 19-125.1, and 19-125.2 et seq., Annotated Code of Maryland

Notice of Proposed Action

[05-003-P]

The Maryland Health Care Commission proposes to amend Regulations **.01 — .05, .07 — .20**, and **.22** under **COMAR 10.24.01 Certificate of Need for Health Care**