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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Waiver for Older Adults Transmittal No. 20
May 4, 2007

To: Waiver for Older Adults Providers

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

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

Re: Waiver for Older Adults - Amended Regulations COMAR 10.09.54

The Maryland Medical Assistance Program has adopted amendments to Regulations .01— .07, .10, .12, .13, .15, .19, .20, .22, .23, .26, .28, .29, .32 — .34 and repealed Regulations .17 and .18 under COMAR 10.09.54 Home/Community Based Services Waiver for Older Adults, effective April 9, 2007. The amendments as published in the January 19, 2007 issue of the Maryland Register are attached.

Following is a summary of the amendments:

1. Adds Definitions:
   - Certificate or license
   - Cost Neutrality
   - Medical Day Care
   - Reportable Events
   - Residential Service Agency

2. Unit of Service
   - Clarifies that a unit of service equals one hour for behavioral consultation, personal care, respite care, dietitian and nutritionist services, and family or consumer training

3. Participant Eligibility
   - Requires that a participant use one waiver service in a twelve month period to retain waiver eligibility

- Clarifies COMAR provisions for optionally categorically needy applicants and participants
- Case manager authorizes medical day care service and frequency of medical day care attendance

4. Personal Needs Allowance
   - Establishes that personal needs allowance under the Waiver for Older Adults will be the same as the nursing facility personal needs allowance

5. Effective Date of Waiver Eligibility
   - Formalizes the criteria used by the Department of Health and Mental Hygiene (DHMH) and the Maryland Department of Aging (MDoA) to establish an applicant's effective date of waiver eligibility

6. Annual Cap on Waiver Participants and the Waiting List
   - Allows individuals on the waiting list to have an opportunity to apply as openings become available
   - Allows individuals who are receiving Medicaid services in a nursing facility for at least 30 days to apply directly to waiver without being registered on the waiting list

7. Conditions for Participation - General
   - Establishes provider notice requirements to MDoA for reasons of closure, relocation, sale of business and changes in ownership, business name, or tax identification number
   - Requires purchaser of an assisted living facility to apply for licensure and Medicaid waiver enrollment in time to assure continuity of services to participants
   - Requires compliance with the DHMH Reportable Event policy
   - Requires Personal Care Agencies to submit an application and pay for a criminal history record check for employed personal care aides to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services and maintain a copy of the criminal history report in the employee's personnel record
   - Clarifies that self-employed providers must request that the Department of Public Safety and Correctional Services submit the original criminal background check report to MDoA
   - Clarifies that providers and their principals who owe Medicaid money are not eligible to enroll as providers

8. Conditions for Participation – Personal Care
   - Formalizes the requirement to submit staff credentials of current employees to MDoA on a monthly basis
   - Requires agency to attend a personal care agency provider orientation
   - Requires a residential services agency to be licensed to provide skilled nursing and aide services

- Clarifies that nurse monitors may be required to conduct a supervisory visit of the aide more frequently than monthly if authorized by the participant's plan of care and requires nurse monitor to maintain detailed written documentation of supervision and obtain various signatures

9. Conditions for Participation – Assisted Living
   - Requires that the alternate assisted living manager meet same requirements as the assisted living manager
   - Requires provider to facilitate delivery of authorized waiver services as well as Medicaid State Plan services according to plan of care
   - Requires provider to facilitate participant's relocation, if necessary

10. Conditions for Participation – Family or Consumer Training
    - Clarifies the licensure requirements for residential service agencies

11. Respite Care
    - Clarifies the licensure requirements for residential service agencies that are eligible to provide these services
    - Limits Medicaid reimbursement to twelve units of respite care per date of service at the participant's residence with an annual limit of 168 hours per calendar year
    - Specifies Medicaid reimbursement for fourteen days of respite care per calendar year provided at an assisted living or nursing facility enrolled as a waiver provider

12. Environmental Modifications and Assistive Devices/Equipment
    - Establishes that environmental modification services in assisted living facilities are no longer reimbursable under the waiver
    - Assistive Devices and Assistive Equipment are combined into one service.

13. Recovery of Funds and Reimbursement
    - Specifies causes for recovery of funds by DHMH
    - Specifies reasons for withholding of payments by DHMH or its designees and fair hearing rights

Any questions regarding the content of this transmittal should be directed to the DHMH Division of Waiver Programs at 410-767-5220.

cc: Maryland Department of Aging
Area Agencies on Aging

(c) Availability of licensed healthcare professionals with experiences in the provision of services to individuals with traumatic brain injury to supervise, train, or consult with program staff regarding the needs of waiver participants; or

(2) Accreditation by CARF for the provision of brain injury services;

[E. Employ appropriately credentialed staff to meet the participants' needs, with specialized training and experience in providing services to individuals with TBI;]

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

[H. Provide a continuing education program, approved by MHA, to assure that direct care staff have ongoing training in the needs of individuals with TBI;]

G. Provide an annual continuing education program approved by MHA for all staff working with waiver participants on the needs of individuals with TBI that may include:

(1) Types of brain injury;

(2) Behavioral, emotional, cognitive, and physical changes after brain injury; and

(3) Strategies for compensation and remediation of deficits caused by a brain injury;

[I.] *H.* Provide services in accordance with the requirements of Regulation .04 of this chapter and all applicable federal, State, and local laws and regulations; [and]

[J.] *I.* Agree to provide and bill MHA or its authorized representative for only those services covered under this chapter which have been preauthorized in the participant's waiver plan of care[.]; *and*

J. Be ineligible to participate in the TBI Waiver if the provider or any of its principals were previously Medicaid providers, or its principals were principals of Medicaid providers that have overpayments that remain due and owing to the Department.

.06 Conditions for Provider Participation — Specific.

A. Provider of Residential Habilitation or Rehabilitation Services. To provide the services covered under Regulation .07 of this chapter, the provider agency shall:

(1) Operate a community-based program of residential habilitation or rehabilitation services that is[:

(a) Accredited by CARF for the provision of brain injury services; or

(b) Licensed] *licensed* by the Department's Office of Health Care Quality under COMAR 10.22.08 for the Community Residential Services Program;

(2) — (3) (text unchanged)

B. Provider of Day Habilitation Services. To provide the services covered under Regulation .08 of this chapter, the provider agency shall operate a community-based program of day habilitation services that is [:

(1) Accredited by CARF for the provision of brain injury services; or

(2) Licensed] *licensed* by the Department's Office of Health Care Quality under COMAR 10.22.07, Vocational and Day Services Program Service Plan.

C. Provider of Supported Employment Services. To provide the services covered under Regulation .09 of this chapter, the provider agency shall operate a community-based program of supported employment services that is:

[(1) Accredited by CARF for the provision of vocational or supported employment services;]

[(2)] *(1)* — [(3)] *(2)* (text unchanged)

D. Provider of Individual Support Services. To provide the services covered under Regulation .09-1 of this chapter, the provider agency shall operate a community-based program of individual support services that is licensed by the Department's Office of Health Care Quality under COMAR 10.22.06 for Family and Individual Support Services.

.09-1 Covered Services — Individual Support Services

A. Individual support services, as defined in Regulation .01B of this chapter, shall be provided in a community setting, including the participant's home, excluding a community-based residential facility.

B. Individual support services shall assist participants to live as independently as possible in their own homes.

C. The provider shall provide services in collaboration with the participant's other TBI waiver services, clinical treatment, and health and medical services.

D. Individual support services shall be provided as preauthorized by MHA in the waiver plan of care and provided in 1-hour units.

.11 Limitations.

A. — B. (text unchanged)

C. The Program shall reimburse for a participant not more than:

(1) — (2) (text unchanged)

(3) One unit of supported employment per day; [or]

(4) A combined maximum of five units of supported employment and day habilitation per week [.] *; or*

(5) Eight units of individual support services for a date of service.

D. The Program does not cover the following:

(1) — (8) (text unchanged)

(9) Payment for residential habilitation on the same date of service as residential rehabilitation services as defined in COMAR 10.21.22; [or]

(10) Payment for supported employment on the same date of service as mental health vocational supported employment as defined in COMAR 10.21.28[.] *;*

(11) Payment for individual support services on the same day as residential habilitation services as defined in Regulation .01B of this chapter; or

(12) Payment for individual support services on the same day as family and individual support services as defined in Regulation .01B of this chapter.

S. ANTHONY McCANN
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.54 Home/Community Based Services Waiver for Older Adults

Authority: Health-General Article, §§2-104(b), 15-103, 15-105, and 15-132, Annotated Code of Maryland

Notice of Proposed Action

[07-027-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.01 — .07, .10, .12, .13, .15, .19, .20, .22, .23, .26, .28, .29, .32 — .34** and repeal in their entirety Regulations **.17** and **.18** under **COMAR 10.09.54 Home/Community Based Services Waiver for Older Adults.**

Statement of Purpose

The purpose of this action is to clarify certain provider requirements, add definitions, and establish provider notice requirements to the Department for reasons of closure, relocation, change in ownership, business name, or tax identification number. The proposal adds a requirement for certain

providers to submit staff credentials to the Maryland Department of Aging, establishes the authority of waiver case managers to authorize participants' frequency of attendance at a medical day care center, establishes that a certain service is no longer reimbursable under the waiver, and combines two related services into one service.

The proposal specifies reasons for recovery of funds by the Department, delineates the process for determining a participant's waiver eligibility date, clarifies the process for applying for waiver services when there is a waiting list, clarifies the process for providers to obtain criminal background histories, adds a new requirement to comply with waiver Reportable Events policy, and clarifies the duties of a nurse monitor.

Comparison to Federal Standards

There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.

Estimate of Economic Impact

I. Summary of Economic Impact. The Program is no longer covering environmental modifications in assisted living facilities.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	(E-)	$13,400
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	**Magnitude**
D. On regulated industries or trade groups:	(-)	$13,400
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

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

A. Approximately $53,600 in expenditures for environmental modifications in assisted living facilities was incurred in the most recent year for which data are available. It is expected that one-fourth of the amount will be incurred during the remainder of this fiscal year. Fifty percent of this amount is federal funds.

D. Approximately $53,600 in expenditures for environmental modifications in assisted living facilities was incurred in the most recent year for which data are available. It is expected that one-fourth of the amount will be incurred during the remainder of this fiscal year. Fifty percent of this amount is federal funds.

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 an impact on individuals with disabilities as follows: The proposal has a positive impact on individuals with disabilities due to ensuring participant's right to choose certain service providers and to decide with case manager their desired frequency of receiving medical day care services. Additionally, this proposal adds provider requirements to report employee credentials for quality assurance purposes and adds sanctions for the Department to apply if providers' actions or inactions pose a serious risk to participant well-being.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulations and Policy Coordination, DHMH, 201 W. Preston St., Room 512, Baltimore, MD 21201, or call 410-767-5623, or email to regs@dhmh.state.md.us, or fax to 410-333-7687. Comments will be accepted through February 20, 2007. A public hearing has not been scheduled.

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) "Adult evaluation and review services (AERS)" means an entity in the local health department which, in accordance with the waiver, COMAR 10.09.30, and this chapter:

(a) — (b) (text unchanged)

(c) [Convenes and participates] *Participates* on a multidisciplinary team to develop a waiver applicant's plan of care; and

(d) [Reconvenes and participates] *Participates* on a multidisciplinary team to review, and revise as necessary, a participant's plan of care at least every 12 months.

(3) — (6) (text unchanged)

(6-1) "Cost neutrality" means costing not more to the Medical Assistance Program in the community receiving waiver and other Program services than in a nursing facility;

(6-2) "Certificate or license" means a certificate or license granted after completing the provisional period mandated by the licensing agency.

(7) — (12) (text unchanged)

(12-1) "Medical day care" means a program of medically supervised, health-related services provided in an ambulatory setting to medically handicapped adults who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living in accordance with COMAR 10.09.07.

(13) — (14) (text unchanged)

(15) "Multidisciplinary team" means a group comprised of a licensed registered nurse [and] *or* licensed social worker from AERS, the participant's case manager, the participant or authorized representative, or both, and, as appropriate, the participant's physician, dietitian or nutritionist, and other service providers.

(16) — (23) (text unchanged)

(23-1) "Reportable events" means an allegation of, or an actual occurrence of, an incident that may pose an immediate or serious risk to the physical or mental health, safety, or well-being of a waiver applicant or participant, or complaints regarding administrative service or quality of care issues.

(23-2) "Residential service agency" means a licensed:

(a) Individual, partnership, firm, association, corporation, or other business entity of any kind that is engaged in a nongovernmental business of employing or contracting with individuals to provide at least one home health care service for compensation to an unrelated sick or disabled individual in the residence of that individual; or

(b) Agency that employs or contracts with individuals directly for hire as home health care providers.

(24) — (27) (text unchanged)

.02 Licensing and Certification Requirements.

A. — D. (text unchanged)

E. Providers of services under §§A — D of this regulation shall have certificates or licenses as defined in Regulation .01B of this chapter to provide services for waiver participants.

.03 Participant Eligibility.

A. (text unchanged)

B. Technical Eligibility. An individual shall be determined by the Maryland Department of Aging or its designee as meeting the technical eligibility criteria for waiver services if the individual:

(1) — (3) (text unchanged)

(4) Has a plan of care that:

(a) — (f) (text unchanged)

(g) Includes:

(i) — (iv) (text unchanged)

(v) Type, amount, frequency, cost, and duration of the waiver and other long-term care Program services required[, and];

(vi) Authorization and frequency of attendance of medical day care services for participants who have this service included in their plan of care; and

[(vi)] *(vii)* (text unchanged)

(5) — (6) (text unchanged)

(7) Is offered the choice between waiver and nursing facility services; [and]

(8) Chooses, or the individual's authorized representative chooses on the individual's behalf, to receive waiver services[.]; *and*

(9) Uses at least one waiver service within a 12-month period.

C. Medical Assistance Eligibility.

(1) Definitions.

(a) "Community spouse" means an individual who:

(i) Lives in the community [outside an institution], *not in a long term care facility*;

(ii) — (iii) (text unchanged)

(b) "Continuous period of institutionalization" means:

(i) *At least* 30 consecutive days of [institutional care] *long term care services* in a nursing facility or other [medical institution] *long term care facility*; or

(ii) (text unchanged)

(c) "Institutionalized spouse" means an *institutionalized* individual who is married to a community spouse and who:

(i) Is an inpatient in a nursing facility or other [medical institution] *long term care facility* with a length of stay [exceeding] *at least* 30 days; or

(ii) (text unchanged)

(2) Categorically Needy. An individual is eligible for waiver services as categorically needy if the individual is receiving Medical Assistance as a:

(a) Recipient of Supplemental Security Income (SSI); [or]

(b) Member of a low income family with children, as described in §1931 of the Social Security Act[.]; *or*

(c) Recipient eligible in another mandatory or optional categorically needy coverage group with full Medical Assistance benefits, covered in the community under the State Plan.

(3) Optionally Categorically Needy.

(a) — (c) (text unchanged)

(d) For the purpose of determining countable resources for the optionally categorically needy, resources are determined based on the resource rules set forth in [Regulations .08, .10, and .10-1 of] COMAR 10.09.24, which are applicable to aged, blind, or disabled [persons] *individuals* who are institutionalized, with the exceptions specified at §C(6) of this regulation.

(4) Medically Needy. An individual is eligible for waiver services if the individual is receiving Medical Assistance as an aged, blind, or disabled medically needy [person under COMAR 10.09.24] *individual in accordance with COMAR 10.09.24.03D and .09.*

(5) An individual is not eligible to receive waiver services if a disposal of assets or establishment of a trust *or annuity* results in a penalty under [Regulation .08-1 or Regulation .08-2 of] COMAR 10.09.24, until such time as the penalty period expires.

(6) All provisions of COMAR 10.09.24 which are applicable to aged, blind, or disabled institutionalized persons are applicable to waiver applicants and participants *who are considered as optionally categorically needy under §C(3) of this regulation*, with the following exceptions:

(a) COMAR 10.09.24.04J(1) — (3);

[(a)] *(b)* — [(d)] *(e)* (text unchanged)

[(e) COMAR 10.09.24.10B(2);

(f) COMAR 10.09.24.10B(3);

(g) COMAR 10.09.24.10C(4) — (7);

(h) COMAR 10.09.24.10D(2)(a), (b), and (c);

(i) COMAR 10.09.24.10D(3) — (5);

(j) COMAR 10.09.24.10-1B(1);

(k) COMAR 10.09.24.10-1B(4);

(l) COMAR 10.09.24.10-1B(7);

(m) COMAR 10.09.24.10-1C(3)(a); and]

(f) COMAR 10.09.24.09;

(g) COMAR 10.09.24.10;

(h) COMAR 10.09.24.10-1; and

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

(7) (text unchanged)

(8) Post Eligibility Determination of Available Income.

(a) For individuals eligible under §C(3) of this regulation who reside in an assisted living facility, the Department shall reduce its monthly payment for assisted living services specified in Regulation .16 of this chapter by the amount remaining after deducting from the individual's total non-excluded monthly income the following amounts in the following order:

(i) A personal needs allowance, consisting of [$60] *the amount established in accordance with COMAR 10.09.24.10D(2)(c)* and the assisted living provider's monthly charge, not exceeding $420, to the participant for room and board;

(ii) (text unchanged)

(iii) Incurred medical expenses [described at COMAR 10.09.24.10D(2)(d) and (e)] *in accordance with COMAR 10.09.24.10D(2)(f) and (g).*

(b) — (e) (text unchanged)

D. Waiver Eligibility. Based on the criteria established in §§A — C of this regulation:

(1) An applicant's eligibility for services under this chapter shall be established by the Department and the Maryland Department of Aging [;] *based on the following policies for the effective date of waiver eligibility:*

(a) No retroactive eligibility; and

(b) Waiver eligibility may not begin before the latest of the following five dates:

(i) Waiver application date;

(ii) Effective date of medical certification for the waiver's institutional level of care;

(iii) Date that the applicant's written waiver plan of care is established, which shall include at least one waiver

service and may be a provisional plan for not more than the first 60 days of waiver enrollment;

(iv) Date that the applicant or representative signed a form designated by the Department to indicate the choice of waiver services as an alternative to institutionalization; and

(v) Date of the applicant's discharge from institutionalization in a long term care facility, if applicable;

(2) (text unchanged)

(3) The participant's eligibility shall be terminated as of the effective date established for ineligibility, when the Department or the Maryland Department of Aging or its designee confirms that a participant no longer qualifies for waiver services *or is no longer utilizing at least one waiver service within a 12-month period* in accordance with the requirements at §§A — C of this regulation.

E. Annual Cap and Waiting List for Waiver Participation.

(1) — (3) (text unchanged)

(4) Once the annual cap on waiver participation is reached:

(a) A waiting list shall be established [of qualified] *for* individuals [for enrollment in the waiver; and] *interested in applying for waiver services;*

(b) [No additional qualified individual may be enrolled in the waiver during that State fiscal year, unless:] *Individuals on the waiting list shall have an opportunity to apply to the waiver as openings become available; and*

[(i) The Department and CMS may authorize increasing the waiver cap; and

(ii) The Department determines that sufficient Program funds are available to reimburse the services recommended in the individual's plan of care and the participant's other Program services for the remainder of the State fiscal year.]

(c) The Department and CMS may authorize increasing the waiver cap if the Department determines that sufficient Program funds are available to reimburse the services recommended in the individual's plan of care and the participant's other Program services for the remainder of the State fiscal year.

(5) Individuals in nursing facilities who are receiving Medicaid services for at least 30 days may apply directly to the waiver without being registered on the waiting list.

.04 Conditions for Participation — General.

General requirements for participation in the Maryland Medical Assistance program are that a provider shall:

A. — H. (text unchanged)

I. Agree to provide and bill the Program for only those services covered under this chapter which have been:

(1) Included in a participant's plan of care;

(2) Preauthorized as indicated by the Maryland Department of Aging's *or its designee's* signature on the plan of care; and

(3) (text unchanged)

J. Render services in accordance with the participant's plan of care[.];

K. Be determined ineligible to participate in the Waiver for Older Adults if the provider or any of its principals were previously Medicaid providers, or its principals were principals of Medicaid providers, that have overpayments that remain due and owing the Department;

L. Implement the reporting and follow-up of incidents and complaints in accordance with the Department's established reportable events policy by:

(1) Reporting incidents and complaints to the participant's case manager within 24 hours;

(2) Submitting a written report within 7 calendar days on a form designated by the Department; and

(3) Notifying the local department of social services immediately if the provider has a reason to believe that the participant has been subjected to abuse, neglect, self-neglect, or exploitation, in accordance with COMAR 07.06.04;

M. Require personal care agencies to:

(1) Submit an application and pay for a criminal history record check for personal care aides to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services;

(2) Employ personal care aides that have not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants; and

(3) Maintain a copy of the criminal history report for all personal care aides in the employee's personnel record;

N. Require self-employed providers to:

(1) Submit an application for a criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services;

(2) Pay for the criminal background check;

(3) Request the Department of Public Safety and Correctional Services to send the criminal history report to the Maryland Department of Aging; and

(4) Not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants;

O. Have the option to request the Department to waive the provisions of Regulation .06B(6) of this chapter if the applicant demonstrates that:

(1) The conviction, probation before judgment, or plea of nolo contendere for a felony or any crime involving moral turpitude or theft was entered more than 10 years before the date of the provider application; and

(2) The criminal history does not indicate behavior that is potentially harmful to participants;

P. Notify the Maryland Department of Aging in writing at least 45 days in advance of any:

(1) Voluntary closure;

(2) Change of ownership;

(3) Change of location;

(4) Sale of the business;

(5) Change in the name under which the provider is doing business; or

(6) Change in provider tax identification number;

Q. Include in the notice to the Maryland Department of Aging the method for informing waiver participants and representatives of its intent to close, change ownership, change location, or sell its business;

R. Apply for a new license if applicable, whenever ownership is to be transferred from the person or organization named on the license to another person or organization in time to assure continuity of waiver services; and

S. Submit a Medicaid provider application to the Maryland Department of Aging if the new owner chooses to participate in the waiver program.

.05 Specific Conditions for Participation — Assisted Living, Environmental Assessments, Behavior Consultation, and Senior Center Plus.

A. Assisted Living. Specific requirements for participation in the Program as an assisted living services provider are that a provider shall:

(1) — (3) (text unchanged)

(4) Employ an alternate assisted living manager who meets the requirements as specified in §A(3) of this regulation.

[(4)] *(5)* — [(6)] *(7)* (text unchanged)

[(7) If environmental modifications included in a participant's plan of care are estimated to cost over $500, obtain at least two bids or prices from licensed contractors and accept the lowest bid that is preauthorized by the Maryland Department of Aging or its designee and meets the requirements in terms of the nature of the work and reasonable quality standards;]

(8) Cooperate with other service providers and quality assurance monitors by:

(a) — (c) (text unchanged)

(d) Informing the case manager within 1 working day of any significant change in the participant's status and service needs; [and]

(e) Facilitating, as necessary and appropriate, the delivery [by other service providers] of *authorized* waiver and [other] *State Plan* services in the [facility, including environmental assessments, behavior consultation services, and a nurse's quality assurance monitoring and review of medication administration] *plan of care*; and

(f) Facilitating waiver participant's relocation to comparable housing, if necessary, including transfer of all personal belongings and financial arrangements; and

(9) Submit claims consistent with provisions of Regulation [.33C(4)(b) and (c)] *.33* of this chapter.

B. — F. (text unchanged)

.06 Specific Conditions for Participation — Personal Care.

A. (text unchanged)

B. To qualify as a personal care aide for a specific participant, providing the services covered under Regulation .22E of this chapter, an individual:

(1) — (11) (text unchanged)

(12) Before performing any delegated nursing functions specified in Regulation .22E(3) of this chapter, shall, *in accordance with Regulation .01B(6-2) of this chapter,* be:

(a) — (b) (text unchanged)

C. (text unchanged)

D. A personal care provider agency shall:

(1) Be an agency which is:

(a) (text unchanged)

(b) [Certified] *Licensed* by the Department as a residential services agency *as defined in Regulation .01B of this chapter to provide skilled nursing and aide services* in accordance with COMAR 10.07.05;

(c) — (d) (text unchanged)

(2) — (4) (text unchanged)

(5) Ensure that the nurse monitor conducts a supervisory visit of the personal care aide in the participant's residence at least every month [to review quality of care by observing and monitoring the aide's performance and interaction with the participant;] *or at a greater frequency in accordance with the plan of care by:*

(a) Observing and monitoring the aide's performance and interaction with the participant; and

(b) Maintaining detailed, written documentation of supervision provided to personal care providers which includes dates of all supervisory visits and signatures from each personal care aide, nurse monitor, and waiver participant;

(6) For each participant receiving personal care nurse monitor services from the personal care provider agency:

(a) — (b) (text unchanged)

(c) Maintain copies of each criminal [background] *history* report, cardiopulmonary resuscitation, first aid certification, and recertification of personal care aides for review by Maryland Department of Aging or its designee;

(d) Ensure that a personal care nurse monitor employed by or under contract with the personal care provider agency provides nursing supervision of the personal care aide, as specified in Regulation .22F of this chapter; [and]

(7) Have a personal care nurse monitor employed by or under contract with the provider agency visit the participant's home to provide nursing oversight, in accordance with COMAR 10.27.11 and other requirements of the Maryland Board of Nursing[:];

[(a) At least every:

(i) 45 days if a personal care aide administers medications to the participant,

(ii) 3 months if the personal care aide assists the participant with self-administration of medications, or

(iii) 4 months if the personal care aide does not administer medications or assist with medication self-administration for the participant; or

(b) At a greater frequency established by the personal care nurse monitor due to the participant's medical condition or clinical status.]

(8) Submit a current list of all employees on a monthly basis to the Maryland Department of Aging, certifying that all employees providing services to waiver participants have met all requirements and have appropriate documentation in their employee file as specified in §B of this regulation; and

(9) Attend a personal care agency provider orientation.

.07 Specific Conditions for Participation — Respite Care.

A. Specific requirements for participation in the Program as a provider of respite care services under Regulation .23 of this chapter are that a respite care provider shall be:

(1) (text unchanged)

(2) An agency or facility that is:

(a) (text unchanged)

(b) [Certified] *Licensed* by the Department as a residential services agency in accordance with COMAR 10.07.05 *and shall obtain a license as defined in Regulation .01B(6-2) of this chapter;*

(c) — (d) (text unchanged)

B. — D. (text unchanged)

.10 Specific Conditions for Participation — Family or Consumer Training.

Specific requirements for participation in the Program as a provider of family or consumer training under Regulation .26 of this chapter are that a provider shall:

A. Be:

(1) (text unchanged)

(2) [Certified] *Licensed* by the Department as a residential services agency in accordance with COMAR 10.07.05, *and obtain a license as defined in Regulation .01B(6-2) of this chapter;*

(3) — (5) (text unchanged)
B. (text unchanged)

.12 Specific Conditions for Participation — Dietitian and Nutritionist Services.

Specific requirements for participation in the Program as a provider of dietitian and nutritionist services under Regulation .28 of this chapter are that a provider shall be a:

A. Dietitian or nutritionist who is licensed in accordance with COMAR [10.56 Board of Dietetic Practice,] *10.56.01* and Health Occupations Article, Title 5, Annotated Code of Maryland; or

B. (text unchanged)

.13 Specific Conditions for Participation — Assistive Devices *and Equipment*.

The specific requirement for participation in the Program as a provider of assistive devices *and equipment* under Regulation .29 of this chapter is that a provider shall be a Program provider of disposable medical supplies and durable medical equipment under COMAR 10.09.12.

.15 Covered Services — General.

The Program shall reimburse for the services specified in Regulations [.16 — .30] *.16 — .29* of this chapter when these services have been documented, pursuant to the requirements of this chapter, as:

A. — C. (text unchanged)

D. Cost neutral [to the Program as compared with alternative placement in a nursing facility] *in accordance with Regulation .01B(6-1) of this chapter.*

.19 Covered Services — Environmental Assessment.

A. (text unchanged)

[B. This service shall include an on-site environmental assessment of the participant's home or residence, including a licensed assisted living facility.]

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

[E.] *D.* Included in the environmental assessment, as necessary and appropriate, may be:

(1) — (4) (text unchanged)

(5) The participant's need for[:] *assistive devices and equipment; and*

[(a) Assistive equipment or environmental modifications to the facility if the participant resides in a licensed assisted living facility, or

(b) Environmental accessibility adaptations or assistive devices if the participant does not reside in a licensed assisted living facility; and]

(6) (text unchanged)

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

.20 Covered Services — Behavior Consultation Services.

A. Definition. "Unit of service" means an hour [or less] of service rendered by a qualified individual during a home visit to a participant, not including:

(1) — (2) (text unchanged)

B. — D. (text unchanged)

.22 Covered Services — Personal Care.

A. Definitions.

(1) — (2) (text unchanged)

(3) "Unit of service" means an hour [or less] of service rendered by a qualified personal care aide or personal care nurse monitor, during a home visit to a participant.

B. — G. (text unchanged)

.23 Covered Services — Respite Care.

A. Definition. "Unit of service" means an hour [or less] of service delivered to a participant by a qualified respite care worker or qualified facility, except that it means a day of service when delivered in a qualified assisted living facility or nursing facility.

B. (text unchanged)

.26 Covered Services — Family or Consumer Training.

A. Definitions.

(1) "Unit of service" means an hour [or less] of service rendered one-on-one by a qualified provider to a participant or family member in the participant's residence or the provider's office, not including the time spent by the provider:

(a) — (b) (text unchanged)

(2) — (3) (text unchanged)

B. — E. (text unchanged)

.28 Covered Services — Dietitian and Nutritionist Services.

A. Definition. "Unit of service" means an hour [or less] of service rendered one-on-one by a qualified provider for a participant in the participant's home or the provider's office.

B. — D. (text unchanged)

.29 Covered Services — Assistive Devices *and Equipment*.

A. (text unchanged)

B. Assistive devices *and equipment* may include, but are not limited to, the following non-medical items for an individual living at home, not in an assisted living facility:

(1) — (3) (text unchanged)

C. Assistive devices *and equipment* shall only be covered under this regulation if the item is:

(1) — (4) (text unchanged)

.32 Limitations.

A. (text unchanged)

B. Reimbursement by the Program for assistive *devices and* equipment covered under [Regulation .17 of this chapter and assistive devices covered under] Regulation .29 of this chapter is limited to $1,000 per participant during a 12-month period, with exceptions allowed at the Department's discretion in unusual circumstances.

C. Reimbursement by the Program for [environmental modifications covered under Regulation .18 of this chapter and] environmental accessibility adaptations covered under Regulation .24 of this chapter:

(1) — (2) (text unchanged)

D. Reimbursement by the Program shall be limited to:

(1) 12 units of [service] *respite care* per date of service [for respite care] *provided at the participant's residence not to exceed 168 hours per calendar year*;

(2) 14 [dates of service for] *days of* respite care *per calendar year provided at a licensed assisted living facility or nursing home enrolled to provide respite services* [during a 12-month period];

(3) Four units of [service] *nurse monitoring* per date of service [for personal care nurse monitor services]; and

(4) Two units of [service] *home-delivered meals* per date of service [for home-delivered meals].

[E. Only assisted living providers may be reimbursed for the following services covered under Regulations .16 — .18 of this chapter only for assisted living residents:

(1) Assisted living services;

(2) Environmental modifications; and

(3) Assistive equipment.]

[F.] *E.* The following services are covered under Regulations .22 — .29 of this chapter only for participants not residing in a licensed assisted living facility:

(1) — (7) (text unchanged)

(8) Assistive devices *and equipment.*

[G.] *F.* The following services are covered under this chapter regardless of the participant's place of residence:

(1) (text unchanged)

(2) Behavior consultation services; *and*

(3) Senior Center Plus[; and].

[(4) Extended home health services.]

[H.] *G.* The Program may not reimburse the following combinations of services for a participant for the same date of service:

(1) Senior Center Plus under this chapter and State Plan medical day care under COMAR 10.09.07; *or*

(2) Personal care, respite care, or assisted living services under this chapter and State Plan personal care under COMAR 10.09.20[; or].

[(3) Extended home health services under this chapter and State Plan home health services under COMAR 10.09.04.]

.33 Payment Procedures.

A. Request for Payment.

(1) An approved provider shall submit requests for payment for [the] services [covered under this chapter] according to procedures set forth in *this chapter and* COMAR 10.09.36.04.

(2) — (5) (text unchanged)

(6) Documentation Required.

(a) Payments by the Program or its designee may be withheld if the provider fails to submit requested evidence of staff qualifications, corrective action plans, or other types of documentation related to ensuring health and safety of participants.

(b) Payments shall be released upon receipt by the Program or its designee of the requested documentation.

(c) An appeal by the provider under COMAR 10.01.03 does not stay the withholding of payments.

B. (text unchanged)

C. Payments.

(1) — (3-1) (text unchanged)

(4) Assisted Living Services.

(a) — (b) (text unchanged)

(c) Payment for assisted living services shall be reduced by 25 percent per day for each day during the month that the participant receives medical day care services in accordance with COMAR 10.09.07 [on the same day].

(d) (text unchanged)

[(5) Environmental Modifications.

(a) An assisted living services provider shall assume 1/3 of the approved cost of environmental modifications rendered to the provider's assisted living facility on behalf of one or more participants.

(b) If the environmental modifications were rendered on behalf of more than one participant, the amount billed shall be divided equally among invoices submitted on behalf of the impacted participants, to total not more than the total amount eligible for billing.

(c) The assisted living services provider shall directly pay its contractor for the environmental modifications rendered, based on a bid submitted by the contractor that was approved by the plan of care and the Maryland Department of Aging.

(6) Assistive Equipment. The assisted living services provider shall:

(a) Pay directly the actual seller of an item of assistive equipment purchased for the use of one or more participants;

(b) Bill the Program the actual purchase price for each item of assistive equipment, as preauthorized by the plan of care and the Maryland Department of Aging or its designee with the cost divided equally among invoices submitted for participants on whose behalf the item was purchased; and

(c) Submit to the Maryland Department of Aging or its designee documentation from the seller of the assistive equipment as to the actual purchase price.]

[(7)] *(5)* — [(17)] *(15)* (text unchanged)

.34 Recovery and Reimbursement.

A. Recovery and reimbursement [is] *are* as set forth in COMAR 10.09.36.07.

B. The causes for recovery and reimbursement include but are not limited to:

(1) Operating without a valid required license;

(2) Using staff that do not meet conditions for participation in accordance with Regulation .04 of this chapter to provide services to waiver participants;

(3) Lacking adequate documentation of services that are billed to the Program;

(4) Submitting claims for services not authorized in the participant's plan of care; and

(5) Providing services that are not in accordance with the requirements of this chapter and other applicable regulations and law.

S. ANTHONY McCANN
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[07-021-P]

The Secretary of Health and Mental Hygiene proposes to amend:

(1) Regulations .01 and .06 under COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment;

(2) Regulations .03, .15 and .19-3 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations;

(3) Regulation .06 under COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access; and

(4) Regulations .22 and .28 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits.

Statement of Purpose

The purpose of this action is to:

(1) Add two new programs, Employed Person with Disabilities and Adult Primary Care, to the list of recipients not eligible for HeathChoice;

(2) Change language regarding effective date of disenrollment when a member relocates out-of-State to coincide with current operating procedures and clarify that the relocation must be permanent;

(3) Allocate 25 percent of the Statewide supplemental payment to increase MCO quality performance measure incentives;

(4) Add language requiring MCOs to participate in a monthly enrollment reconciliation process;