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

PT 8-07

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 62
August 22, 2006

TO: Managed Care Organizations

FROM: Diane Herr, Director
HealthChoice and Acute Care Administration
Office of Health Services

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

RE: Proposed Amendments to HealthChoice Regulations

WRITTEN COMMENTS TO:
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COMMENT PERIOD EXPIRES: September 18, 2006

The Maryland Medical Assistance Program is promulgating proposed amendments to Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions; Regulation .06 under COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment; Regulations .06, .10, .14, .17, .20, .22 and .25 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; Regulations .04, .07 and .08 under COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access; Regulations .01—.05, .07—.19, and .21—.28 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits; Regulations .02, .05, .07, .09, .12, and .13 under COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management; Regulations .07 and .10 under COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health

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

The proposed amendments will:

(1) Remove the term "medically appropriate" from all Managed Care regulations;

(2) Allow all enrollees 90 days from initial enrollment in an MCO to change MCOs.

(3) Require that MCO subcontracts contain a provision to the effect that each of the provision required under COMAR 10.09.65.17A(4), supersede and be controlling over any conflicting terms that appear in the subcontract;

(4) Correct the due date for MCO outreach plans from January 1 to December 1 of each year;

(5) Require MCOs to respond to preauthorization requests within 2 days of receipt of all necessary clinical information and no longer than 7 calendar days of the initial request;

(6) Add a Comprehensive Substance Abuse Assessment (CSAA) to the list of Self-Referral Services;

(7) Remove reference to COMAR 10.21.10 which was repealed; and

(8) Correct the time frame for expedited appeals to 20 days.

A copy of the proposed amendments, as published in the August 18, 2006 issue of the Maryland Register, is attached.

Attachment

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[06-234-P]

The Secretary of Health and Mental Hygiene proposes to amend:

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

(2) Regulation **.06** under **COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment**;

(3) Regulations **.06, .10, .14, .17, .20, .22,** and **.25** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations**;

(4) Regulations **.04, .07,** and **.08** under **COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access**;

(5) Regulations **.01 — .05, .07 — .19,** and **.21 — .28** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**;

(6) Regulations **.02, .05, .07, .09, .12,** and **.13** under **COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management**;

(7) Regulation **.07** and **.10** under **COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System**; and

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

Statement of Purpose

The purpose of this action is to:

(1) Remove the term "medically appropriate" from all Managed Care regulations;

(2) Allow all enrollees 90 days from initial enrollment in an MCO to change MCOs;

(3) Require that MCO subcontracts contain a provision to the effect that each of the provisions required under COMAR 10.09.65.17A(4) supersede and be controlling over any conflicting terms that appear in the subcontract;

(4) Correct the due date for MCO outreach plans from January 1 to December 1 of each year;

(5) Require MCOs to respond to preauthorization requests within 2 days of receipt of all necessary clinical information and not longer than 7 calendar days of the initial request;

(6) Add a Comprehensive Substance Abuse Assessment (CSAA) to the list of Self-Referral Services;

(7) Remove reference to COMAR 10.21.10 which was repealed; and

(8) Correct the time frame for expedited appeals to 20 days.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

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

Impact on Individuals with Disabilities

The proposed action has an impact on individuals with disabilities as follows:

Proposed regulations have a positive impact in that they will clarify the definition of medical necessity, the time frames for medical authorizations and the availability of a comprehensive substance abuse assessment as a self referred service and provide all enrollees the opportunity to change MCOs once during their initial enrollment in an MCO.

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 September 18, 2006. A public hearing has not been scheduled.

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) — (13) (text unchanged)

(14) "Benefits package" means a set of health care services to which an MCO's enrollees are entitled, when the services are medically necessary **[**and appropriate**]**, and which the MCO delivers to its enrollees either through providers with which it has employment or contractual relationships, or through reimbursement for services provided to the MCO's enrollees.

(15) — (21) (text unchanged)

(22) Case Management.

(a) "Case management" means, in the context of COMAR 10.09.63 — 10.09.69 and 10.09.71 — 10.09.73, assessing, planning, coordinating, monitoring, and arranging the delivery of medically necessary **[**and appropriate**]** health-related services.

(b) (text unchanged)

(23) — (105-2) (text unchanged)

(106) **[**"Medically appropriate" means an effective service that, with respect to enrollees who are 21 years old or older, can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any alternative services which could be used for the same purpose.**]** Repealed.

(107) (text unchanged)

(108) **[**"Medically necessary and appropriate" means medically necessary and medically appropriate.**]** Repealed.

(109) "Medical necessity" means what is medically necessary **[**and appropriate**]**.

(110) — (143) (text unchanged)

(144) "Primary care" means medical care that addresses a patient's general health needs, including the coordination of the patient's health care, with the responsibility for the prevention of disease, promotion and maintenance of health, treatment of illness, maintenance of the enrollee's health records, and referral for medically necessary **[**and appropriate**]** specialty care.

(145) — (147) (text unchanged)

(148) "Primary mental health services" means the clinical evaluation and assessment of mental health services needed by an individual and the provision of services or referral for additional services as deemed medically necessary **[**and appropriate**]** by a primary care provider.

(149) — (202) (text unchanged)

10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment

Subtitle 09 MEDICAL CARE PROGRAMS

Authority: Health-General Article, §15-103(b)(3), (23), Annotated Code of Maryland Regulations

.06 Disenrollment.

A. Enrollee-Initiated Disenrollment for Cause.

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

(a) — (e) (text unchanged)

(f) The enrollee is automatically assigned to an MCO [and the enrollee requests to enroll into another MCO] *or it is the enrollee's initial enrollment in an MCO* as follows:

(i) Only one request during the first [year] *90 days* of automatic assignment *or initial enrollment* into an MCO; and

(ii) (text unchanged)

(g) — (h) (text unchanged)

(2) — (4) (text unchanged)

B. Department-Initiated Disenrollment. The Department shall disenroll from an MCO an enrollee:

(1) Subject to the MCO obtaining the Department's determination that the enrollee's institutionalization has been medically necessary [and appropriate], who has been continuously institutionalized for a period of more than 30 successive days in:

(a) — (b) (text unchanged)

(2) — (10) (text unchanged)

C. — F. (text unchanged)

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Insurance Article, §15-605; Health-General Article, §§2-104 and 15-103; Annotated Code of Maryland [; Ch. 202 and 203, Acts of 2003]

.06 Special Needs Populations — Individuals with a Physical Disability.

A. — B. (text unchanged)

C. Before placement of an individual with a physical disability into an intermediate or long-term care facility, an MCO shall:

(1) — (2) (text unchanged)

(3) If the MCO's medical director determines that the transfer to an intermediate or long- term care facility is medically necessary [and appropriate] and that the expected stay will be greater than 30 days, obtain approval from the Department before making the transfer.

D. — E. (text unchanged)

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

A. — B. (text unchanged)

C. AIDS Case Management Services.

(1) An MCO shall ensure that an enrollee with HIV/AIDS receives case management services that:

(a) — (b) (text unchanged)

(c) Ensure timely and coordinated access to medically necessary [and appropriate] levels of care that support continuity of care across the continuum of service providers;

(d) — (e) (text unchanged)

(2) (text unchanged)

D. — F. (text unchanged)

.14 Referral to Specialty Mental Health Delivery System.

A. An MCO is responsible for providing medically necessary [and appropriate] primary mental health services to their enrollees.

B. — E. (text unchanged)

.17 Subcontractual Relationships.

A. Subcontracting Permitted.

(1) — (3) (text unchanged)

(4) An MCO shall use subcontracts that are in writing and include at least the following:

(a) — (h) (text unchanged)

(i) A provision that no assignment of the subcontract by the subcontractor is effective without prior written notice to the Department; [and]

(j) If the subcontractor is authorized by the MCO to make referrals, a provision requiring the subcontractor to use the uniform consultation referral form adopted by the Maryland Insurance Administration at COMAR 31.10.12.06[.]; *and*

(k) A provision to the effect that each provision of the subcontract that is required under this section supersede and be controlling over any conflicting terms that appear in the subcontract.

(5) (text unchanged)

B. — E. (text unchanged)

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

A. MCO Payment for Self-Referred Services.

(1) — (6) (text unchanged)

(7) An MCO shall reimburse out-of-plan providers at the Medicaid rate for medically necessary [and appropriate] pharmacy and laboratory services when the pharmacy or laboratory service is provided:

(a) — (b) (text unchanged)

(8) — (9) (text unchanged)

B. If the claim is submitted to the MCO within 9 months of the date of service, an MCO shall reimburse a hospital emergency facility and provider, which is not required to obtain prior authorization or approval for payment from an MCO in order to obtain reimbursement under this regulation, for:

(1) — (2) (text unchanged)

(3) Medically necessary [and appropriate] services if the MCO authorized, referred, or otherwise allowed the enrollee to use the emergency facility and the medically necessary [and appropriate] services are related to the condition for which the enrollee was allowed to use the emergency facility; and

(4) Medically necessary [and appropriate] services that relate to the condition presented and that are provided by the provider in the emergency facility to the enrollee if the MCO fails to provide 24-hour access to a physician.

C. (text unchanged)

.22 Stop Loss Program.

A. — B. (text unchanged)

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] 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] 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. — I. (text unchanged)

.25 Enrollee Outreach Plan.

A. (text unchanged)

B. Submission Date.

(1) (text unchanged)

(2) An MCO shall submit by [January] *December* 1 of each year an enrollee outreach plan, including the information specified in §A of this regulation, to be reviewed as part of the annual audit performed by an external quality review organization (EQRO).

10.09.66 Maryland Medicaid Managed Care Program: Access

Authority: Health-General Article, §§15-102.1(b)(10) and 15-103(b), Annotated Code of Maryland

.04 Access Standards: Information for Providers.

A. An MCO shall develop and issue to all of its PCP and specialty care providers a Medicaid requirements manual, including periodic updates as appropriate, and shall:

(1) (text unchanged)

(2) Include in its manual the information necessary to facilitate the providers' full compliance with federal and State Medicaid requirements, including information on:

(a) — (d) (text unchanged)

(e) The MCO's requirements for referral to specialist, ancillary, and other providers as necessary to provide the full range of medically necessary [and appropriate] services that are covered by the Maryland Medicaid Managed Care Program; and

(3) Inform the MCO's primary and specialty care providers of their responsibility to provide or arrange for medically necessary [and appropriate] accessible health care services that are continuous, comprehensive, and coordinated for each enrollee, including:

(a) — (i) (text unchanged)

B. — C. (text unchanged)

.07 Access Standards: Clinical and Pharmacy Access.

A. (text unchanged)

B. An MCO shall respond in a timely manner to its enrollees' needs and requests, as follows:

(1) — (3) (text unchanged)

(4) For services to enrollees that require preauthorization by the MCO, the MCO shall provide the preauthorization in a timely manner so as not to adversely affect the health of the enrollee[,] *and within 2 business days of receipt of necessary clinical information* but not later than [72 hours] *7 calendar days* [after] *from* the *date of the* initial request; and

(5) (text unchanged)

C. (text unchanged)

D. Clinical Access Outside the MCO's Service Area.

(1) Subject to §D(2) of this regulation, an MCO shall be financially responsible for medically necessary [and appropriate] emergency services delivered to its enrollees outside of the MCO's service area.

(2) (text unchanged)

E. (text unchanged)

.08 Emergency Services Access.

A. (text unchanged)

B. An MCO shall provide medically necessary [and appropriate] emergency services 24- hours per day, 7-days per week.

C. — E. (text unchanged)

F. An MCO shall reimburse, within 30 days of invoice, the undisputed claims of hospital emergency facilities and providers for the following services provided to the MCO's enrollees:

(1) — (2) (text unchanged)

(3) If the MCO authorized, referred, or otherwise allowed the enrollee to use the emergency facility, medically necessary [and appropriate] services that are related to the condition for which the enrollee was allowed to use the emergency facility; and

(4) If the MCO fails to provide 24-hour access to a physician, medically necessary [and appropriate] services that relate to the condition presented and that are provided by the provider in an emergency facility to the enrollee.

G. (text unchanged)

10.09.67 Maryland Medicaid Managed Care Program: Benefits

Authority: Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland

.01 Required Benefits Package — In General.

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

B. — F. (text unchanged)

.02 Benefits — Primary Care Services.

An MCO shall provide to its enrollees medically necessary [and appropriate] primary care services that are provided:

A. — C. (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) — (4) (text unchanged)

B. (text unchanged)

.04 Benefits — Pharmacy Services.

A. An MCO shall provide to its enrollees all medically necessary [and appropriate] pharmaceutical services and pharmaceutical counseling, including but not limited to:

(1) — (12) (text unchanged)

B. — C. (text unchanged)

D. Drug Formulary.

(1) — (4) (text unchanged)

(5) To ensure that its formulary drugs are medically [appropriate] necessary, safe, and efficacious, an MCO shall:

(a) — (b) (text unchanged)

E. — F. (text unchanged)

.05 Benefits — Home Health Services.

A. Subject to the conditions specified in §B of this regulation, an MCO shall provide to its enrollees medically necessary [and appropriate] home health services, including:

(1) — (6) (text unchanged)

B. (text unchanged)

.07 Benefits — Inpatient Hospital Services.

A. An MCO shall provide to its enrollees medically necessary [and appropriate] inpatient hospital services as specified in this regulation.

B. Admission to Long-Term Care Facility.

(1) An MCO shall provide to its enrollees medically necessary [and appropriate] long- term care facility services for:

(a) (text unchanged)

(b) Any days following the first 30 continuous days of an admission until the date the MCO has obtained the Department's determination that the admission is medically necessary [and appropriate] as specified in §B(2) of this regulation.

(2) At the time of effecting any long-term care facility admission that is expected to result in a length of stay exceeding 30 days, an MCO shall secure a determination by the Department that the admission is medically necessary [and appropriate].

(3) (text unchanged)

C. The Department shall render a determination with respect to the medical necessity [and appropriateness] of a stay in a long-term care facility as specified in §B of this regulation within 3 business days of receipt of a complete application from the MCO.

D. — G. (text unchanged)

.08 Benefits — Outpatient Hospital Services.

An MCO's benefits package shall include medically necessary [and appropriate] outpatient hospital services.

.09 Benefits — Transplants.

An MCO shall provide to its enrollees medically necessary [and appropriate] transplants.

.10 Benefits — Substance Abuse Treatment Services.

A. An MCO shall provide to its enrollees medically necessary [and appropriate] comprehensive substance abuse treatment services in accordance with the standards set forth in COMAR 10.09.65.11 — .11-2, including but not limited to:

(1) — (2) (text unchanged)

(3) Detoxification treatment, on either an outpatient, or, if medically necessary [and appropriate], an inpatient basis;

(4) — (6) (text unchanged)

B. — C. (text unchanged)

.11 Benefits — Diagnostic and Laboratory Services.

An MCO shall provide to its enrollees medically necessary [and appropriate]:

A. — B. (text unchanged)

.12 Benefits — 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 for:

(1) (text unchanged)

(2) Any days following the first 30 continuous days of an admission until the date the MCO has obtained the Department's determination that the admission is medically necessary [and appropriate] as specified in §C of this regulation.

B. — C. (text unchanged)

D. At the time of effecting any nursing facility admission that is expected to result in a length of stay exceeding 30 days, the MCO shall secure a determination by the Department that the admission is medically necessary [and appropriate].

E. The Department shall render a determination with respect to the medical necessity [and appropriateness] of a stay in a nursing facility as specified in §C of this regulation within 3 business days of receipt of a complete application from the MCO.

F. A determination by the Department that the admission is medically necessary [and appropriate] does not relieve the MCO of the obligation to pay for the admission through the day on which the determination is made.

.13 Benefits — Disposable Medical Supplies and Durable Medical Equipment.

A. An MCO shall provide to its enrollees medically necessary [and appropriate] disposable medical supplies and durable medical equipment, including but not limited to:

(1) — (2) (text unchanged)

B. — D. (text unchanged)

.14 Benefits — Vision Care Services.

A. An MCO shall provide to its enrollees medically necessary [and appropriate] vision care services as specified in this regulation.

B. (text unchanged)

C. For its enrollees who are younger than 21 years old, the MCO is responsible for providing medically necessary vision services, including but not limited to:

(1) — (2) (text unchanged)

(3) Contact lenses, if medically necessary and if eyeglasses are not [medically appropriate] *efficacious* for the condition.

.15 Benefits — Podiatry Services.

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

A. — C. (text unchanged)

.16 Benefits — Outpatient Rehabilitative Services.

An MCO shall provide to its enrollees medically necessary [and appropriate] outpatient rehabilitative services, including but not limited to physical therapy for adult enrollees.

.17 Benefits — Oxygen and Related Respiratory Equipment.

An MCO shall provide to its enrollees medically necessary [and appropriate] oxygen and related respiratory equipment services.

.18 Benefits — Dialysis Services.

An MCO shall provide to its enrollees medically necessary [and appropriate] dialysis services.

.19 Benefits — Family Planning Services.

An MCO shall provide to its enrollees comprehensive family planning services, including but not limited to medically necessary [and appropriate] office visits, laboratory tests, contraceptive devices, and voluntary sterilizations.

.21 Benefits — Pregnancy-Related Services.

A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary [and appropriate] pregnancy-related services, including:

(1) — (2) (text unchanged)

(3) Enriched maternity services, including:

(a) — (f) (text unchanged)

(g) Medically necessary [and appropriate] dental services for pregnant enrollees who are 21 years old or older, as specified in Regulation .06 of this chapter.

B. — C. (text unchanged)

D. An MCO shall provide for home visits required by §§B and C of this regulation to be performed by a registered nurse and in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child, including:

(1) — (3) (text unchanged)

(4) Referrals for any medically necessary [and appropriate] continuing health care services; and

(5) (text unchanged)

.22 Benefits — Case Management Services for HIV-Infected Individuals.

An MCO shall provide medically necessary [and appropriate] case management services to its qualifying enrollees, as specified in COMAR 10.09.65.10B.

.23 Benefits — Hospice Care Services.

A. An MCO shall include in its benefits package medically necessary [and appropriate] hospice care services to enrollees who are terminally ill.

B. — C. (text unchanged)

.24 Benefits — Diabetes Care Services.

A. An MCO shall provide to its qualifying enrollees medically necessary [and appropriate] diabetes care services as specified in this regulation.

B. (text unchanged)

C. In addition to the services included in its usual benefits package, an MCO shall provide, at least to the enrollees who qualify under §B of this regulation, the following medically necessary [and appropriate] special diabetes-related services:

(1) — (2) (text unchanged)

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

(a) — (e) (text unchanged)

(4) (text unchanged)

.25 Benefits — Blood and Blood Products.

An MCO shall provide to its enrollees medically necessary [and appropriate] blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.

.26 Benefits — Primary Mental Health Services.

An MCO shall provide to its enrollees medically necessary [and appropriate] primary mental health services, including appropriate referrals to the Department's specialty mental health delivery system, as described in COMAR 10.09.70.

.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) — (33) (text unchanged)

(34) Genotypic, phenotypic, or other HIV/AIDS drug resistance testing used in the treatment of HIV/AIDS, the provision of which will be reimbursed directly by the Department if the service is:

(a) (text unchanged)

(b) Medically necessary [and appropriate];

(35) — (36) (text unchanged)

.28 Benefits — Self-Referral Services.

An MCO shall be financially responsible for reimbursing, in accordance with COMAR 10.09.65.20, an out-of-plan provider chosen by the enrollee for the following services:

A. — F. (text unchanged)

G. Initial medical examination of a newborn when the:

(1) (text unchanged)

(2) MCO failed to provide for the service before the newborn's discharge from the hospital[.]; *and*

H. A comprehensive substance abuse assessment (CSAA), as described in COMAR 10.09.65.11, if the following conditions are met:

(1) The recipient is not in substance abuse treatment;

(2) The recipient has not received a self-referred CSAA that calendar year; and

(3) The assessment provider is an Alcohol and Drug Abuse Administration certified substance abuse provider.

10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management

Authority: Health-General Article, §§15-102.1(b)(1) and 15-103(b)(4)(i), Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Additional Terms Defined. "Cause" means a significant change in medical condition such that it is no longer medically [appropriate] *efficacious* for the individual to remain in the MCO as determined by the Department.

.05 Benefits.

A REM participant is eligible for the following:

A. (text unchanged)

B. Services described in Regulations .10 and .11 of this chapter when determined medically necessary [and, for adults, appropriate] by the Department; and

C. Case management services performed by a REM case manager who shall:

(1) — (5) (text unchanged)

(6) Implement the plan of care and assist the participant in gaining access to medically necessary [and appropriate] services by linking the participant to those services;

(7) — (10) (text unchanged)

.07 Conditions for Participation — General Requirements.

An individual, agency, or provider rendering services or medical care pursuant to this chapter shall:

A. — F. (text unchanged)

G. Notify the Department in writing within 10 business days when a service requested by a participant is deemed not medically necessary [and, for adults, not medically appropriate];

H. — L. (text unchanged)

.09 Covered Services — General Requirements.

For participants in the REM program, the Program covers and shall reimburse for services specified in Regulations .10 and .11 of this chapter when these services are:

A. (text unchanged)

[B. For adults, medically appropriate;]

[C.] *B.* — [G.] *F.* (text unchanged)

.12 Limitations.

A. — B. (text unchanged)

C. The REM program does not cover the following:

(1) — (2) (text unchanged)

[(3) For adults, services which are not medically appropriate;]

[(4)] *(3)* — [(11)] *(10)* (text unchanged)

.13 Preauthorization Requirements.

A. (text unchanged)

B. The Department shall issue preauthorization when the Department:

(1) Determines that services are medically necessary [and, for adults, medically appropriate]; and

(2) (text unchanged)

C. Authorization of services shall be rescinded by the Department when:

(1) — (2) (text unchanged)

(3) The Department determines the care is no longer medically necessary; *or*

[(4) For adults, the Department determines the care is no longer medically appropriate; or]

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

10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System

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

.07 Preauthorization.

A. — B. (text unchanged)

C. The SMHS UR agent shall preauthorize services that are:

(1) Medically necessary [and appropriate]; and

(2) (text unchanged)

D. — H. (text unchanged)

.10 Mental Health Diagnoses and Service Array.

A. — B. (text unchanged)

C. Service Array. Mental health services include:

(1) (text unchanged)

(2) As State resources permit, the following services, which are not Medicaid- reimbursable:

(a) Residential programs, including:

(i) — (ii) (text unchanged)

(iii) Psychiatric halfway house services,[under COMAR 10.21.10,] and

(iv) (text unchanged)

(b) — (g) (text unchanged)

D. — E. (text unchanged)

10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures

Authority: Health-General Article, §15-103(b)(9)(i)(4), Annotated Code of Maryland

.05 Enrollee Appeal.

A. — B. (text unchanged)

C. Hearings.

(1) (text unchanged)

(2) In appeals concerning the medical necessity [or appropriateness] of a denied benefit or service, an expedited hearing shall be scheduled within [15] *20* days of the receipt by the Office of Administrative Hearings of the notice of appeal, and a decision shall be rendered within 30 days of the hearing.

(3) In cases other than those concerning the medical necessity [or appropriateness] of a denied benefit or service, the hearing shall be scheduled within 30 days of the receipt by the Office of Administrative Hearings of the notice of appeal, and a decision shall be rendered within 30 days of the hearing.

(4) — (7) (text unchanged)

D. — E. (text unchanged)

S. ANTHONY McCANN
Secretary of Health and Mental Hygiene

Title 11
DEPARTMENT OF TRANSPORTATION

Subtitle 15 MOTOR VEHICLE ADMINISTRATION — VEHICLE REGISTRATION

Notice of Proposed Action

[06-231-P]

The Administrator of the Motor Vehicle Administration proposes to:

(1) Amend Regulations **.02**, **.04**, and **.05**, repeal existing Regulation **.03**, and adopt new Regulation **.03** under **COMAR 11.15.16 Issuance, Renewal, Display, and Expiration of Registrations**; and

(2) Amend Regulations **.01** and **.02** and repeal Regulation **.04** under **COMAR 11.15.17 Staggered System of Registration**.

Statement of Purpose

The purpose of this action is to add classes of vehicles to the 2-year registration renewal schedule, to specify what classes of vehicles require 1-year registration renewals, to repeal an obsolete regulation, and to add language to reference current statute and enhance the regulation. This action will also update the regulations to make them consistent with current policy.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The impact of switching to a 2-year registration schedule from an annual registration is to transfer the annual registration renewal fee from one year to the next year. The increase in 2-year registration renewals would increase the Transportation Trust Fund's (TTF) revenue in FY 2007, but revenues would decrease in FY 2008 because of a decrease in registration renewals. The amount of the increases and decreases will depend on the number of vehicle owners affected by the 2-year registration renewal schedule. TTF revenues in future years will fluctuate due to the 2-year or annual registration schedule.

There would be an estimated increase in TTF expenditure of approximately $440,240 in FY 2007 due to the anticipated October 1, 2006 effective date. This includes $154,340 for additional employee salaries with fringe benefits, one-time start-up costs, and ongoing operating expenses as well as an estimated $285,900 for computer programming costs.