STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

Office of Health Services
Medical Care Programs

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 26

November 7, 2001

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.

Proposed Amendments to HealthChoice Regulations

ACTION:
Proposed Regulations

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:
Division of HealthChoice Management
(410) 767-1482 or call
1-877-4MD-DHMH extension 1482

COMMENT PERIOD EXPIRES: November 19, 2001

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.19, .21** and **.22**, repeal existing Regulations **.19-1** and **19-2**, adopt new Regulation **.19-1**, and amend and recodify Regulations **.19-3** and **19-4** to be Regulations **.19-2** and **.19-3-** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed**

Care Organizations; and repeal Regulations **.02** and **.04—.07,** and amend and recodify Regulation **.03** to be regulation **.02** under **COMAR 10.09.74 Maryland Medicaid Managed Care Program; Contribution to Graduate Medical Education Costs.**

The proposed amendments will:

1) Establish new HealthChoice capitation rates for CY 2002;
2) Delete out- of- date provisions within the regulations such as the HIV supplemental payments;
3) Add language for new supplemental payments for medical expenses for individuals with Hepatitis C;
4) Amend and simplify out-of-date provisions within the regulations;
5) Make the correction to refer to SOBRA in each area that previously reference PWC;
6) Change the rates MCOs pay to FQHCs with which they contract; and
7) Remove and amend the requirements to submit GME Primary Care and Innovation Plans and GME Allocation Plans.

Attachment

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[01-357-P]

The Secretary of Health and Mental Hygiene proposes to (1) Amend Regulations .19, .21, and .22, repeal existing Regulations .19-1 and .19-2, adopt new Regulation .19-1, and amend and recodify Regulations .19-3 and .19-4 to be Regulations .19-2 and .19-3 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; and (2) Repeal Regulations .02 and .04 — .07, and (3) amend and recodify Regulation .03 to be Regulation .02 under COMAR 10.09.74 Maryland Medicaid Managed Care Program: Contribution to Graduate Medical Education Costs.

Statement of Purpose

The purpose of this action is to establish new HealthChoice capitation rates for CY 2002. In addition, the action deletes out-of-date provisions within the regulations such as the HIV supplemental payments, provides for new supplemental payments such as coverage for medical expenses for individuals with Hepatitis C, amends and simplifies out-of-date provisions within the regulations, makes technical corrections such as referring to SOBRA in each area that previously referenced PWC, changes the rates MCOs pay to FQHCs with which they contract, and removes and amends the requirements to submit GME Primary Care and Innovation Plans and GME Allocation Plans.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed regulation.

Estimate of Economic Impact

I. Summary of Economic Impact. There will be a positive economic impact to MCO's and MCO's subcontracted providers.

II. Types of Economic Impacts.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	(E+)	$80,000,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	**Magnitude**
D. On regulated industries or trade groups:		
Managed Care Organizations	(+)	$80,000,000
E. On other industries or trade groups:		
MCO subcontracted providers	(+/-)	Unknown
F. Direct and indirect effects on public:	NONE	

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

A, D, and E. The Department's projected calendar year 2002 expenditure will increase by 7.9 percent on an MCO base of approximately $1,000,000,000 due to the increase in rates paid to the MCOs. The impact of this increase on the MCO subcontracted provider is unknown.

Economic Impact on Small Businesses

The proposed action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

There may be an undetermined trickle-down economic impact on small provider practices that subcontract with the MCOs.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, Room 521, 201 W. Preston Street, Baltimore, Maryland 21201, or fax to (410) 333-7687, or call (410) 767-6499 or email to regs@dhmh.state.md.us, or call 1-877-4md-dhmh, ext. 6499. These comments must be received by November 19, 2001.

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Health-General Article, §15-103(b)(18) and (26) and (e), Annotated Code of Maryland

.19 MCO Reimbursement.

A. (text unchanged)

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 [PWC] *SOBRA* children, shall be established as follows:

(a) — (b) (text unchanged)

(2) (text unchanged)

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

(a) (text unchanged)

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

[(c) The Department shall pay an MCO a monthly payment for enrollees younger than 1 year old.

(d) The Department shall pay an MCO the applicable monthly payment for enrollees with AIDS and enrollees with HIV as defined in Regulation .19-1B of this chapter, however:

(i) To receive this payment, an MCO shall submit to the Department the name of any enrollee whom the MCO believes qualifies; and

(ii) The Department shall deny payment for any enrollee that it determines ineligible.

(e) MCO HIV Specific Factor.

(i) Effective July 1, 2001, the Department shall pay an MCO a monthly capitation payment for enrollees with HIV based on an MCO-Specific Factor.

(ii) The Department will determine an MCO-Specific Factor which calculates the risk factor for the previous year.

(iii) Each MCO's specific risk adjustor will be applied to the rate cell for each documented HIV enrollee.

(f) The Department shall pay an MCO a transitional monthly capitation rate for any enrollee younger than 1 year old who was born before January 1, 2001.]

(4) The Department shall make capitation payments monthly at the rates specified in the following tables:

(a) — (c) (proposed for repeal)

(a) Rate Table for Families and children.
Effective January 1, 2002 — December 31, 2002.

Demographic Cells	Age	Gender	PMPM Baltimore City	PMPM Rest of State
	Under Age 1	Both	$220.37	$173.73
	1 — 5	Male	$106.78	$84.18
		Female	$83.88	$66.13
	6 — 14	Male	$95.00	$74.89
		Female	$76.92	$60.64
	15 — 20	Male	$180.16	$142.03
		Female	$175.28	$138.18
	21 — 44	Male	$252.96	$199.42
		Female	$226.55	$178.61
	45 — 64	Male	$555.45	$437.90
		Female	$338.84	$267.13
ACG-adjusted cells				
ACG 100, 200, 300, 500, 600, 1100, 1600, 2000, 2400, 3400, 5110, 5200	RAC1	Both	$65.54	$64.20
ACG 400, 700, 900, 1000, 1200, 1300, 1710, 1800, 1900, 2100, 2200, 2300, 2800, 2900, 3000, 3100, 5310	RAC2	Both	$92.57	$90.70
ACG 1720, 1730, 2500, 3200, 3300, 3500, 3800, 4210, 5320, 5339	RAC3	Both	$122.21	$120.31
ACG 800, 1740, 1750, 2700, 3600, 3700, 3900, 4000, 4100, 4220, 4310, 4410, 4510, 4610, 4710, 4720, 4810, 5340	RAC4	Both	$184.72	$180.77
ACG 1400, 1500, 1760, 1770, 2600, 4320, 4520, 4620, 4820	RAC5	Both	$250.17	$244.60
ACG 4330, 4420, 4830, 4910, 4920, 5010, 5020, 5040	RAC6	Both	$348.15	$338.16
ACG 4430, 4730, 4930, 5030, 5050	RAC7	Both	$655.73	$636.66
ACG 4940, 5060	RAC8	Both	$683.62	$663.97
ACG 5070	RAC9	Both	$876.87	$853.78
SOBRA Mothers			$372.88	$293.96
Newborns / Delivery			$10,478.70	$8,261.00
Persons with HIV	All	Both	$726.54	$726.54

(b) Rate Table for Disabled Individuals. Effective January 1, 2002 — December 31, 2002.

Demographic Cells	Age	Gender	PMPM Baltimore City	PMPM Rest of State
	Under Age 1	Both	$1,663.94	$1,663.94
	1 — 5	Male	$586.19	$586.19
		Female	$651.83	$651.83
	6 — 14	Male	$324.34	$324.34
		Female	$384.86	$384.86
	15 — 20	Male	$269.57	$269.57
		Female	$302.35	$302.35
	21 — 44	Male	$671.63	$529.49
		Female	$691.70	$545.31
	45 — 64	Male	$859.85	$677.88
		Female	$760.08	$599.21
	RAC10	Both	$138.40	$134.47
ACG — adjusted cells				
ACG 100, 200, 300, 1100, 1300, 1400, 1500, 1600, 1710, 1720, 1730, 1900, 2400, 2600, 2900, 3400, 5110, 5200, 5310	RAC11	Both	$271.84	$264.35
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	RAC12	Both	$465.66	$452.81
ACG 600, 1760, 3600, 3700, 4100, 4320, 4410, 4710, 4810, 4820	RAC13	Both	$549.33	$535.33
ACG 3800, 4210, 4220, 4330, 4420, 4720, 4910, 5320	RAC14	Both	$713.59	$690.59
ACG 800, 4430, 4510, 4610, 5040, 5340	RAC15	Both	$802.11	$776.94
ACG 1770, 4520, 4620, 4830, 4920, 5050	RAC16	Both	$935.81	$907.35
ACG 4730, 4930, 5010	RAC17	Both	$1,342.22	$1,298.24
ACG 4940, 5020, 5060	RAC18	Both	$1,928.58	$1,866.97
ACG 5030, 5070	All	Both	$2,751.31	$2,552.35
Persons with ADS	All	Both	$1,616.86	$1,616.86
Persons with HIV				

[(d)] *(c)* 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 based on receipt of benefits through TCA or programs for medically needy families and children, including [PWC] *SOBRA* children.

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

[(f) Interpretation of Rate Table for Transitional Payments. The table found at §B(4)(c) of this regulation shows the transitional monthly capitation rates for any enrollee younger than 1 year old who was born before January 1, 2001.]

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

(5) (text unchanged)

C. — D. (text unchanged)

.19-1 Risk Sharing — Medical Expenses of Enrollees with Hepatitis C.

A. The Department shall, to the extent provided by this regulation, share a portion of the participating MCO's calendar year 2002 financial risk associated with its enrollees with Hepatitis C.

B. The Department shall make a supplemental payment to each MCO for the MCO's cost of pharmacy-dispensed drugs used in the treatment of Hepatitis C for enrollees with one of the following as the primary, secondary, tertiary, or level 4 diagnosis:

(1) 070.41 — Acute or Unspecified Hepatitis C with hepatic coma;

(2) 070.44 — Chronic Hepatitis C with hepatic coma;

(3) 070.51 — Acute or unspecified Hepatitis C without mention of hepatic coma; or

(4) 070.54 — Chronic Hepatitis C without mention of hepatic coma.

C. MCO drug costs qualifying for supplemental payments pursuant to this regulation are limited to:

(1) Pharmacy-dispensed drugs that have received approval from the federal Food and Drug Administration for the treatment of Hepatitis C; and

(2) With respect to epoetin alfo, only an enrollee with HIV.

D. The Department shall base its calculation of the supplemental payment on pharmacy encounters included in each MCO's reported encounter data that:

(1) Are received by the Department as of March 31, 2003;

(2) Reflect services that:

(a) Meet the criteria set forth in §C of this regulation; and

(b) Were delivered to enrollees who are members of the eligible population specified in §B of this regulation; and

(3) Reflect service costs incurred during calendar year 2002.

E. Supplemental Payment. Consistent with the terms and limitations set forth in this regulation, the Department shall make supplemental payments to MCOs as follows:

(1) Except as provided in §E(2) of this regulation, the Department shall pay 50 percent of the cost of drugs:

(a) Meeting the criteria set forth in this regulation; and

(b) Delivered in connection with a reported pharmacy encounter;

(2) The Department's aggregate payments to all MCOs may not exceed $2,000,000; and

(3) The Department shall make supplemental payments required by this regulation not later than June 1, 2003.

[.19-3] *.19-2* MCO Supplemental Payment for Transitional Encounter Data Adjustment.

A. [During calendar year 2001 the] *The* Department [shall] *may* grant an adjustment to those MCOs for whom the uniform encounter data adjustment results in completeness factors that are below the Statewide average.

B. (text unchanged)

[C. The Department shall calculate a monthly adjustment payment on the total MCO RAC revenue for the preceding service month by multiplying the MCO RAC revenues by the appropriate transitional encounter data factor.

D. The specific transitional encounter data factors are as follows:

(1) Maryland Physicians Care MCO:

(a) Family and Children RACs — 0.4 percent,

(b) Disabled RACs — 0.0 percent;

(2) AMERICAID Community Care:

(a) Family and Children RACs — 2.0 percent;

(b) Disabled RACs — 2.0 percent;

(3) FreeState Health Plan:

(a) Family and Children RACs — 0.6 percent,

(b) Disabled RACs — 1.7 percent;

(4) Helix Family Choice, Inc.:

(a) Family and Children RACs — 0.0 percent,

(b) Disabled RACs — 3.7 percent;

(5) Priority Partners MCO:

(a) Family and Children RACs — 0.0 percent,

(b) Disabled RACs — 1.0 percent.]

[.19-4] *.19-3* MCO Statewide Supplemental Payment.

A. On the payment dates specified in §B of this regulation, the Department shall make a Statewide supplemental payment to any MCO that has a membership in each of at least 20 of the 24 State jurisdictions, and meets [at least one of] the following conditions:

[(1) Has a membership of at least 5 percent of the total Program membership in each of at least 20 of the 24 State jurisdictions; or]

[(2)] *(1)* As of April 1, [2001] *2002*, has been approved for participation in each of at least 20 of 24 State jurisdictions; *and*

(2) The MCO [and has not restricted] *has decided to operate without restricted* enrollment in [any jurisdiction for which the MCO has less than 5 percent of the program membership in that jurisdiction] *at least 20 State jurisdictions.*

B. MCOs are eligible to receive a supplemental payment or payments if the following conditions are met:

(1) [April 2001] *June 2002* payment:

(a) The MCO's Provider Agreement is current[,]; *and*

(b) The MCO has committed to remaining in the Program through June 30, [2001, and] *2002*;

[(c) The qualifications in §A of this regulation were met as of September 1, 2000;]

(2) [October 2001] *December 2002* payment;

(a) The MCO's Provider Agreement is current[,]; *and*

(b) The MCO has committed to remaining in the Program through December 31, [2001; and] *2002*.

[(c) The qualifications in §A of this regulation were met as of July 1, 2001.]

C. The [April 2001] *June 2002* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in [August 2000] *May 2002* prospectively for that MCO's [September 2000] *June 2002* enrollment, multiplied by [$15.57] *$12.26* per enrollee.

D. The [October 2001] *December 2002* payment to a qualifying MCO will equal the total number of that MCO's

enrollees paid for in [June 2001] *November 2002* prospectively for that MCO's [July 2001] *December 2002* enrollment, multiplied by [$15.57] *$12.26* per enrollee.

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

A. An MCO shall reimburse an FQHC with which it subcontracts at least [$48.96] *$50.85* per visit for Medicaid covered services other than dental services.

B. An MCO shall reimburse an FQHC with which it subcontracts at least [$14.81] *$15.49* per visit for dental services to recipients younger than 21 years old and to pregnant women.

C. — E. (text unchanged)

.22 Stop Loss Program.

A. An MCO shall qualify for protection under the Stop Loss Program if:

[(1) Until December 1, 2000, the inpatient hospital costs of an enrollee exceed $61,000 in one contract year and the MCO provides to the Department the notice specified in §B of this regulation.

(2) Beginning December 1, 2000, the inpatient hospital costs exceed $61,000 in one calendar year and the MCO provides the notice specified in §B of this regulation to the Department.]

(1) It was participating in HealthChoice as of April 1, 1999;

(2) It was unable to self-insure or obtain a contract with another entity for Stop Loss reinsurance after July 1, 1999; and

(3) By July 1, 1999, the MCO requested the Department to continue to provide Stop Loss Protection at a rate determined by the Department.

B. An MCO shall notify the Department that the inpatient hospital costs of an enrollee are expected to exceed [$61,000] *the Stop Loss limit* as soon as it knows that this is likely to occur.

C. — E. (text unchanged)

F. The Department's Extended Stop Loss Period.

(1) [Effective December 1, 2000, if] *If* an inpatient enrollee remains hospitalized at the end of a calendar year and incurs hospital costs that exceed [$61,000] *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 [$61,000] *the Stop Loss limit* for enrollees who remain hospitalized at the end of the calendar year as specified in §§A and D of this regulation until the enrollee is discharged.

[G. An MCO, which is participating as of April 1, 1999, and is unable to self-insure or obtain a contract with another entity for Stop Loss Reinsurance after July 1, 1999, may request the Department to continue to provide Stop Loss protection with the cost borne by the MCO.

H. An entity that becomes certified as an MCO after April 1, 1999, is required to self-insure or otherwise obtain a contract with another entity for Stop Loss Reinsurance after July 1, 1999.

I. For Fiscal Year 2000, the MCO shall submit to the Maryland Insurance Administration the MCO's Stop Loss Reinsurance Plan or Self-Insurance Plan described in §G of this regulation.]

[J.] *G* — [K.] *H.* (text unchanged)

[L.] *I.* Upon the termination of the provider agreement between the enrollee's MCO and the Department, if an MCO has failed to fulfill its financial liability [of $61,000 as specified in §§A and D of this regulation for stop loss protection,] *under this regulation,* the Department shall assume responsibility only for costs that exceed [$61,000] *the Stop Loss limit* as specified in §C of this regulation.

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

Authority: Health-General Article, [Title 15 Subtitle 1,] §15-103(b)(18), Annotated Code of Maryland

[.03] .02 GME Allocation Payment.

A. — B. (text unchanged)

[C. Noncompliance Penalty. A teaching hospital that fails to discharge its primary care and innovation responsibilities under this chapter is subject to a noncompliance penalty that reduces the amount of its GME allocation payment to the extend of the teaching hospital's failure to make at least the minimum level of expenditures dedicated to primary care and innovation activities, as required by Regulation .05 of this chapter, as follows.

(1) The noncompliance penalty is expressed as a percentage, calculated by dividing the amount the hospital establishes that it has expended on primary care and innovation activities during the fiscal year by the minimum accepted primary care and innovation expenditure amount for the fiscal year, set forth in Regulation .05D(2) of this chapter;

(2) The noncompliance penalty percentage derived from the calculation described in §C(1) of this regulation is used to reduce the teaching hospital's GME percentage, pursuant to COMAR 10.09.65.18-1A(1)(b); and

(3) The reduction of the noncompliant teaching hospital's assigned GME percentage has the effect, pursuant to §B(5) of this regulation, of reducing the amount of the GME allocation payment due to the hospital in an amount proportional to the shortfall in the teaching hospital's primary care and innovation expenditures for the fiscal year.

D. Multiple Penalties for Noncompliance in Multiple Fiscal Years.

(1) If a teaching hospital submits a primary care and innovation plan that proposes a level of primary care and innovation expenditures lower than the minimum acceptable expenditure for the fiscal year, as established by Regulation .05D(2) of this chapter, the Department shall apply the reduction authorized by §C of this regulation to the four quarterly GME allocation payments paid to the hospital during the fiscal year covered by the plan.

(2) If the Department determines that a teaching hospital did not carry out the terms of its primary care and innovation plan approved for a past fiscal year, and its primary care and innovation expenditures are shown to have been lower than the minimum acceptable level established by Regulation .05B(2) of this chapter for that fiscal year, the Department shall apply the reduction authorized by §C of this regulation to the four quarterly GME allocation payments to be paid to the hospital during the fiscal year beginning July 1 of the next calendar year beginning after the Department determines the amount the hospital actually did devote to primary care and innovation activities during the fiscal year at issue.

(3) If a teaching hospital submits a primary care and innovation plan that proposes insufficient primary care and innovation expenditures, as described in §D(1) of this regulation, and, before the January 1 falling before the beginning of the next fiscal year, the Department determines that

the hospital's primary care and innovation expenditures for a past fiscal year were insufficient, and the extent of the insufficiency, as described in §D(2) of this regulation, the Department shall combine all penalties assessable under §D(1) and (2) of this regulation to reduce the four quarterly GME allocation payments paid to the hospital during the next full fiscal year, as authorized by §C of this regulation.]

GEORGES C. BENJAMIN, M.D.
Secretary of Health and Mental Hygiene

Subtitle 14 CANCER CONTROL

10.14.02 Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment

Authority: Health-General Article, §§2-102, 2-104, and 2-105, Annotated Code of Maryland

Notice of Proposed Action

[01-350-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations .01 — .06, .10, .11, and .13, adopt new Regulation .14, amend and recodify Regulations .14 — .16 to be Regulations .15 — .17, and recodify Regulations .17 — .20 to be Regulations .18 — .21, under COMAR 10.14.02 Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment.

Statement of Purpose

The purpose of this action is to revise the patient financial eligibility scale to be consistent with the Breast and Cervical Cancer Screening Program, define additional participating medical care providers and services, and to clarify Medical Assistance eligibility and experimental treatment as they apply to the reimbursement for breast and cervical cancer diagnosis and treatment.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed regulation.

Estimate of Economic Impact

I. Summary of Economic Impact. This action will impact the Department of Health and Mental Hygiene by requiring payment of breast reconstruction, wigs, and occupational therapy costs for low-income, uninsured or underinsured, non-Medical Assistance participating residents of Maryland who qualify for the Breast and Cervical Cancer Diagnosis and Treatment Program under COMAR 10.14.02. Hospitals, private physicians, home health agencies, and medical supply companies will benefit as indicated below.

The major beneficiary will be low-income, uninsured, and underinsured women who will receive diagnosis and treatment for breast and cervical cancer. All estimates are based on Fiscal Year 2000 experience. These figures have been adjusted to reflect the last 3 months of the fiscal year since it is requested that this chapter become effective April 1, 2002.

II. Types of Economic Impacts.	Revenue (R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency: Department of Health and Mental Hygiene	(E+)	$95,850
B. On other State agencies:	NONE	
C. On local governments:	NONE	
D. On regulated industries or trade groups:		
(1) Hospitals, both inpatient and outpatient	(+)	$73,125
(2) Physicians	(+)	$19,125
(3) Home health agencies	(+)	$3,350
E. On other industries or trade groups: Medical supply companies	(+)	$250
F. Direct and indirect effects on public:	(+)	Significant

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

A. This expenditure estimate represents the cost of the additional providers and services based upon the current Medical Assistance reimbursement rate and the Fiscal Year 2000 figures. The $95,850 estimated expense represents $73,125 for hospital costs, $19,125 for physicians, $3,350 for home health costs, and $250 for medical supply costs.

D(1). Hospitals will benefit from the Program directly by an estimated amount of $73,125 for breast reconstruction based upon the current HSCRC rate, the number of eligible patients who elect to have breast reconstruction, and the method of breast reconstruction chosen.

D(2). Physicians will benefit directly by an estimated $19,125 based upon the current Medical Assistance reimbursement rate for breast reconstruction, the number of eligible patients who elect to have breast reconstruction, and the method of breast reconstruction chosen.

D(3). Home health agencies will benefit directly by an estimated $3,350 based upon the Medical Assistance reimbursement rate and the number of patients requiring occupational therapy services related to breast or cervical cancer.

E. Medical supply companies are expected to benefit directly by an estimated $250 based upon the number of patients actively receiving chemotherapy.

F. The Breast and Cervical Cancer Diagnosis and Treatment Program is projected to serve approximately 1,125 low-income, non-Medical Assistance participating, uninsured, or underinsured residents of Maryland actively involved in diagnosis and treatment per quarter. Of this total, an estimated 45 will need treatment for breast cancer. It is recognized that breast reconstruction is a very important treatment component to the patient physically, psychologically, and emotionally. It is also recognized that not every patient will choose this treatment component. Also, only a portion of those diagnosed with breast cancer will receive chemotherapy, and only this portion will need to obtain a wig to replace hair lost during treatment. Only a portion of those diagnosed with breast cancer will develop the need for occupational therapy services. The benefit to the public is expected to be significant as a result of the treatment and care provided.

Economic Impact on Small Businesses

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

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, 201 W. Preston Street, Room 521, 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. These comments must be received by November 19, 2001.

.01 Scope.

A. (text unchanged)

B. These regulations also define the:

(1) Responsibilities and duties of the Department, the participating local health department, the hospital-