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
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 35
November 1, 2002

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 and Quality Assurance
(410) 767-1482 or call
1-877-4MD-DHMH extension 1482

COMMENT PERIOD EXPIRES: November 18, 2002

The Secretary of Health and Mental Hygiene proposes to amend Regulation .01 under COMAR 10.09.62, Maryland Medicaid Managed Care Program: Definitions; to amend Regulations .03, .04, .07, and .09 under COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application; to amend Regulations .02, .03, .05, .11, .17, .19, 19-3, and .20and adopt new Regulation 19-4 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; to amend Regulations .16, .27, and .28 under COMAR 10.09.67 Maryland Medicaid Managed Care Program:

Benefits; and to amend Regulations .01, .02, and .08 under COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System.

The proposed amendments will:

Amend the payment schedule for MCO reimbursement of self referred services for a child in State-supervised care;

2. Amend MCO Statewide Supplemental Payment regulations;

3. Establish new MCO rates;

4. Amend the MCO payment for enhance dental services regulation;

5. Adopt a new regulation regarding MCO payments for Health Insurance Portability and Accountability Act (HIPAA) compliance;

6. Amend the Benefit- limitations regulation to clarify MCOs are not responsible for OT, PT and speech therapy services unless when they are provided as part of home health services;

7. Remove the language regarding use of American Society of Addictions Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2) and add the requirement to use the current ADAA approved placement criteria;

8. Amend the HealthChoice Quality Assurance regulations;

9. Replace references to Article 48A, 409s with the appropriate Maryland Annotated Code, Insurance Article sections, and amend the Health General citation in MCO Application- Quality Assurance regulations;

10. Amend disclosure of provider incentive plans regulation language; and

11. Remove all the references to RECM and replace them with REM.

Attachment

G. If the Secretary's final decision does not uphold the emergency suspension, the agency may resume operation.

.19 Denial or Revocation of License.

A. Denial or Revocation of License. The Secretary, for cause shown, may notify the agency of the decision to revoke or deny the license. Except as provided in Regulation .18 of this chapter, the denial or revocation shall be stayed if a hearing is requested.

B. Criteria for Denial or Revocation. The Department shall notify the agency in writing of the following:

(1) The effective date of the denial or revocation;

(2) The reason for the denial or revocation;

(3) The regulations with which the licensee has failed to comply that form the basis for the denial or revocation;

(4) That the agency is entitled to a hearing if requested, and to be represented by counsel;

(5) That the agency shall stop providing services on the effective date of the denial or revocation if the agency does not request a hearing;

(6) That the denial or revocation shall be stayed if a hearing is requested; and

(7) That the agency is required to surrender its license to the Department if the denial or revocation is upheld.

C. A person aggrieved by the action of the Secretary under this regulation may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .20 of this chapter.

.20 Hearings.

A. An agency shall file a request for a hearing with the Office of Administrative Hearings, with a copy to the Office of Health Care Quality of the Department, not later than 30 calendar days after receipt of notice of the Secretary's action. This request shall include a copy of the Secretary's action.

B. A hearing requested under this chapter shall be conducted in accordance with:

(1) State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland;

(2) COMAR 28.02.01; and

(3) COMAR 10.01.03.

C. The burden of proof is as provided in COMAR 10.01.03.28.

D. Unless otherwise stated in this chapter, the Office of Administrative Hearings shall issue a proposed decision within the time frames set forth in COMAR 28.02.01.

E. The aggrieved person may file exceptions as provided in COMAR 10.01.03.35.

F. A final decision by the Secretary shall be issued in accordance with COMAR 10.01.03.35.

.21 Funding Availability.

Implementation of this chapter is contingent upon availability of funds in accordance with the State Finance and Procurement Article, §§7-234 and 7-235, Annotated Code of Maryland.

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

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[02-346-P]

The Secretary of Health and Mental Hygiene proposes to:

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

(2) Amend Regulations .03, .04, .07, and .09 under **COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application;**

(3) Repeal existing Regulation .03 and adopt new Regulation .03, amend Regulations .02, .05, .11, .17, .19, .19-3, .20, and .24, and adopt new Regulation .19-4 under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations;**

(4) Amend Regulations .16, .27, and .28 under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits;**

(5) Amend Regulations .01, .02, .05, .07, and .08 under **COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System.**

Statement of Purpose

The purposes of these proposed actions are to:

(1) Amend the payment schedule for Managed Care Organization (MCO) reimbursement of self-referred services for a child in State-supervised care;

(2) Amend MCO Statewide supplemental payment regulations;

(3) Establish new MCO rates;

(4) Amend the MCO payment for enhanced dental services regulation;

(5) Adopt a new regulation regarding MCO payments for Health Insurance Portability and Accountability Act (HIPAA) compliance;

(6) Amend the benefit-limitations regulation to clarify that MCOs are not responsible for occupational therapy, physical therapy, and speech therapy services unless they are provided as part of inpatient hospital or home health services;

(7) Remove the language regarding use of the American Society of Addictions Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2) and add the requirement to use the current ADAA approved placement criteria;

(8) Amend the HealthChoice Quality Assurance regulations;

(9) Replace the Article 48A references with the appropriate Insurance Article references in the Annotated Code of Maryland, and amend the Health-General citation in MCO Application — Quality Assurance regulations;

(10) Amend disclosure of provider incentive plans regulation language; and

(11) Remove all the references to RECM and replace them with REM.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed regulation.

Estimate of Economic Impact

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

II. Types of Economic Impacts.	Revenue (R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency:	(E+)	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (−)	**Magnitude**
D. On regulated industries or trade groups:		
Managed Care Organizations	(+)	$107,000,000
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. The Department's projected January — December 2003 expenditure will increase by 8.5 percent on an MCO base of approximately $1,300,000,000 due to the increase in rates paid to the MCOs. The impact of this increase on the MCO subcontracted provider is unknown.

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

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, Room 521, 201 West Preston Street, Baltimore, Maryland 21201, or fax to (410) 333-7687, or email to regs@dhmh.state.md.us; or call (410) 767-6499, or 1-877-4MD-DHMH, extension 6499. These comments must be received by November 18, 2002.

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) — (11) (text unchanged)

[(12) "American Society of Addictions Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2)" means the nationally recognized clinical guide, published by the American Society of Addictions Medicine, for determining the appropriate level and intensity of care for a patient.]

[(13)] *(12)* — [(74)] *(73)* (text unchanged)

(74) "HIPAA" means the Health Insurance Portability and Accountability Act, a federal law enacted on August 21, 1996, whose purpose is to improve the efficiency and effectiveness of the health care system by standardizing the electronic exchange of administrative and financial data, provide security requirements for transmitted information, and protect the privacy of identifiable health information.

(75) — (138) (text unchanged)

(139) "Placement appraisal" means the process by which a qualified provider determines, based on the [ASAM PPC-2 placement criteria, the appropriate level and intensity of care needed by an enrollee with a substance abuse problem.] *current Alcohol and Drug Abuse Administration approved placement criteria, the appropriate level and intensity of care needed by an enrollee with a substance abuse problem.*

10.09.64 Maryland Medicaid Managed Care Program: MCO Application

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

Authority: Health-General Article, §§15-102 and 15-103, Annotated Code of Maryland

.03 Organization, Operations, and Financing.

Except as provided in Regulation .02B of this chapter, an MCO applicant shall include the following information or descriptions in its application:

A. — E. (text unchanged)

F. If the applicant is an HMO, the most recent annual loss ratio report provided to the Maryland Insurance Administration pursuant to [Article 48A, §490S], *Insurance Article, §5-605*, Annotated Code of Maryland;

G. A copy of the applicant's business plan provided to the Maryland Insurance Administration pursuant to [Article 48A, §490S] *Insurance Article, §5-605*, Annotated Code of Maryland.

H. — T. (text unchanged)

.04 Financial Solvency.

An applicant that is not a certified HMO shall include in its application the following information or descriptions:

A. — E. (text unchanged)

F. Document that the applicant has deposited, in a trust account with the State treasury, $100,000 in cash or government securities of the type described in [Article 48A, §110] *Insurance Article, §5-701(b)*, Annotated Code of Maryland;

G. — H. (text unchanged)

.07 Access and Capacity: Contracts and Provider Applications.

An MCO applicant shall include in its application the following information or descriptions:

A. A description of the applicant's hiring and subcontracting policies, which shall correspond to the requirements of [Article 48A, §490CC(c) — (k)] *Insurance Article, §15-112*, Annotated Code of Maryland;

B. — G. (text unchanged)

.09 Quality Assurance System — General.

Unless an applicant satisfies the requirements of Regulation .08 of this chapter, it shall include in its application the following information or descriptions:

A. — J. (text unchanged)

K. Evidence of an adequate system for medical record retention and retrieval that meets, at minimum, all requirements of Health-General Article, [§15-103(b)(9)(xix)] *§15-103(b)(9)(xiv)*, Annotated Code of Maryland;

L. — P. (text unchanged)

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Health-General Article, §§15-102.4 and 15-103(b), Annotated Code of Maryland

.02 Conditions for Participation.

A. — E. (text unchanged)

F. Assurance Against Insolvency.

(1) — (5) (text unchanged)

(6) Funds designated by the Secretary pursuant to §F(3) — (5) of this regulation shall remain in trust until such time as the Commissioner has determined that the MCO meets the minimum statutory surplus requirements based on the MCO's annual report submitted pursuant to [Article 48A, §490S(b)(1)] *Insurance Article, §5-605*, Annotated Code of Maryland.

(7) (text unchanged)

G. — L. (text unchanged)

M. An MCO shall comply with the provisions of [Article 48A, §490CC] *Insurance Article, §15-112*, Annotated Code of Maryland.

N. — S. (text unchanged)

T. *Disclosure of Provider Incentive Plans.*

(1) An MCO shall disclose to the Department [and, on request, to the U.S. Department of Health and Human Services,] *the information on its provider incentive plans listed in 42 CFR §417.479(h)(1),* [at the times indicated in 42 CFR §434.70(a)(3), in order]*:*

(a) Prior to approval of its contract or agreement; and

(b) Upon the contract's or agreement's anniversary or renewal effective date.

(2) *An MCO shall include in the disclosures required by §T(1) of this regulation information sufficient for the Department* to determine whether the incentive plans meet the requirements of 42 CFR §417.479(d) — (g) and, as applicable (i), when there exist compensation arrangements under which payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under §1903(a) of the Social Security Act.

U. — W. (text unchanged)

.03 Quality Assessment and Improvement.

A. An MCO shall have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees including individuals with special health care needs. At a minimum, the program shall:

(1) Comply with all applicable federal and State laws and regulations;

(2) Comply with all access and quality standards and levels of performance established by the Department including all standards for individuals with special health care needs in Regulations .04 — .11 of this chapter; and

(3) Be able to provide the Department with accurate information in areas including but not limited to:

(a) Provider networks;

(b) Utilization of services; and

(c) Identification and management of individuals with special health care needs, including but not limited to:

(i) Enrollees with HIV;

(ii) Pregnant women;

(iii) Enrollees with disabilities;

(iv) Enrollees who require substance abuse treatment;

(v) Adult enrollees with diabetes;

(vi) Pediatric enrollees with asthma; and

(vii) Children with special health care needs.

B. An MCO shall participate in all quality assessment activities required by the Department in order to determine if the MCO is providing medically necessary and appropriate enrollee health care. Effective January 1, 2002, these activities include, but are not limited to:

(1) An annual quality of care audit performed by an external quality review organization hired by the Department to assess an MCO's structure and operations in order to determine its ability to provide health care to its enrollees as follows:

(a) The audit standards and criteria shall include at a minimum all applicable standards in the Health Care Quality Improvement System (HCQIS);

(b) The audit shall include, but not be limited to:

(i) MCO's Quality Assessment and Improvement program;

(ii) Enrollee rights;

(iii) Access and availability of services;

(iv) Care management;

(v) Enrollee outreach;

(vi) Utilization management and review; and

(vii) MCO organization, operations, and financial management;

(c) The results of the audit shall be reported in draft to the MCOs for comment;

(d) MCO shall submit all comments and any required corrective action within 45 days of receipt of draft report; and

(e) The Department shall issue a final report of the audit results;

(2) The annual collection, validation, and evaluation of the latest approved version of the Health Employer Data and Information Set (HEDIS) in order to assess the access to and quality of services provided as follows:

(a) The Department shall establish the number of HEDIS measures to be collected each year based on relevancy to the HealthChoice population;

(b) At a minimum, at least one measure shall be collected on each of the following:

(i) Prenatal, perinatal, and postnatal care;

(ii) Screening and preventive services for women and children; and

(iii) Children and adults with special health care needs; and

(c) At least 90 days before the audit process, the Department shall identify all measures to be collected as well as the target for each;

(3) The annual collection and evaluation of a set of performance measures with targets as determined by the Department as follows:

(a) The composition of the performance measure set shall include measures from various required quality assessment activities described in this regulation and any other measure established by the Department in order to determine MCO performance in providing health care to enrollees;

(b) With a goal of continuous improvement, targets for each measure shall be based on the most recent available national benchmarking data, or if no national data exists, on the analysis of HealthChoice encounter data;

(c) Each year before the audit period begins, the Department shall identify and obtain public input on all measures to be collected as well as the target for each; and

(d) In accordance with COMAR 10.09.73, MCOs may receive financial or other types of incentives or disincentives based on performance measure results;

(4) An annual enrollee satisfaction survey using the latest version of the Consumer Assessment of Health Plans Survey (CAHPS) conducted by NCQA certified CAHPS vendor;

(5) An annual audit by the Maryland Healthy Kids Program in order to determine the quality of the clinical care provided to all children younger than 21 years old enrolled in the HealthChoice Program as follows:

(a) A unit of registered nurses who are specifically trained to assess MCO and provider performance in the provision of EPSDT services to children shall conduct the audit;

(b) The audit shall include a review of a sample of medical records from each provider reviewed during the calendar year to assess clinical care;

(c) The results of the audit that are below minimum EPSDT standards may result in corrective action required by both the provider and the MCO; and

(d) Audit results shall be included in the annual quality of care audit report; and

(6) Performance improvement projects to be conducted by the MCOs that focus on clinical or nonclinical areas as determined by the Department and include the following:

(a) Measurement of performance using objective quality indicators;

(b) Implementation of system interventions to achieve improvement in quality;

(c) Evaluation of effectiveness of interventions;

(d) Planning and initiation of activities to sustain improvement; and

(e) Reporting of results to the Department.

C. If an MCO is assessed as deficient in accordance with federal and State standards, the MCO shall submit a plan of corrective action to the Department.

.05 Special Needs Populations — Children with Special Health Care Needs.

A. — J. (text unchanged)

K. When a child, who is an MCO enrollee, is diagnosed with a special health care need requiring a plan of care which includes specialty services, [such as physical therapy, occupational therapy, or speech therapy,] and that health care need was undiagnosed at the time of enrollment, the parent or guardian of that child may request approval from the MCO for a specific out-of-network specialty provider to provide those services when the MCO does not have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same service and modality, subject to the following provisions:

(1) — (3) (text unchanged)

.11 Special Needs Populations — Individuals in Need of Substance Abuse Treatment.

A. — E. (text unchanged)

F. When the substance abuse screening described in §D of this regulation confirms the probability of substance abuse, the MCO shall provide the enrollee with:

(1) (text unchanged)

(2) [A placement appraisal to determine, based on the American Society of Addictions Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2), the appropriate level and intensity of care for the enrollee.] *A placement appraisal to determine, based on the current edition of the American Society of Addiction Medicine Patient Placement Criteria, or its equivalent as approved by the Alcohol and Drug Abuse Administration, the appropriate level and intensity of care for the enrollee.*

G. — J. (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) — (i) (text unchanged)

(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 [09.31.23.06.] *31.10.12.06.*

(5) (text unchanged)

B. — E. (text unchanged)

.19 MCO Reimbursement.

A. Generally.

(1) (text unchanged)

(2) An MCO shall be reimbursed at rates set forth in this regulation only for individuals enrolled under the [Maryland Medicaid Managed Care Program] *HealthChoice Managed Care Program.*

(3) — (6) (text unchanged)

B. Capitation Rate-Setting Methodology.

(1) — (3) (text unchanged)

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

(a) — (b) (tables proposed for repeal)

(a) Rate Table for Families and Children
Effective January 1, 2003 — December 31, 2003

Demographic Cells	*Age*	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
	Under Age 1	*Both*	*$246.99*	*$208.94*
	1-5	*Male*	*$127.12*	*$107.54*
		Female	*$115.16*	*$97.42*
		Male	*$91.58*	*$77.47*
		Female	*$78.33*	*$66.26*
	15-20	*Male*	*$121.72*	*$102.97*
		Female	*$173.98*	*$147.18*
	21-44	*Male*	*$283.81*	*$240.09*
		Female	*$256.42*	*$216.91*
	45-64	*Male*	*$778.95*	*$658.94*
		Female	*$529.58*	*$447.99*

Demographic Cells	Age	Gender	PMPM Baltimore City	PMPM Rest of State
ACG-adjusted cells				
ACG 100, 200, 300, 500, 600, 1100, 1600, 2000, 2400, 3400, 5110, 5200	*RAC1*	*Both*	*$75.08*	*$66.48*
ACG 400, 700, 900, 1000, 1200, 1300, 1710, 1800, 1900, 2100, 2200, 2300, 2800, 2900, 3000, 3100, 5310	*RAC2*	*Both*	*$98.71*	*$87.41*
ACG 1720, 1730, 2500, 3200, 3300, 3500, 3800, 4210, 5320, 5339	*RAC3*	*Both*	*$123.26*	*$109.15*
ACG 800, 1740, 1750, 2700, 3600, 3700, 3900, 4000, 4100, 4220, 4310, 4410, 4510, 4610, 4710, 4720, 4810, 5340	*RAC4*	*Both*	*$208.34*	*$184.48*
ACG 1400, 1500, 1760, 1770, 2600, 4320, 4520, 4620, 4820	*RAC5*	*Both*	*$280.81*	*$248.65*
ACG 4330, 4420, 4830, 4910, 4920, 5010, 5020, 5040	*RAC6*	*Both*	*$465.90*	*$412.55*
ACG 4430, 4730, 4930, 5030, 5050	*RAC7*	*Both*	*$587.34*	*$520.09*
ACG 4940, 5060	*RAC8*	*Both*	*$903.84*	*$800.35*
ACG 5070	*RAC9*	*Both*	*$1,429.47*	*$1,265.78*
SOBRA Mothers			*$455.50*	*$385.33*
Newborns / Delivery			*$10,581.79*	*$8,951.61*
Persons with HIV	*All*	*Both*	*$563.30*	*$563.30*

(b) Rate Table for Disabled Individuals. Effective January 1, 2003 — December 31, 2003

Demographic Cells	Age	Gender	PMPM Baltimore City	PMPM Rest of State
	Under Age 1	*Both*	*$1,712.73*	*$1,712.73*
	1-5	*Male*	*$570.25*	*$570.25*
		Female	*$623.51*	*$623.51*
	6-14	*Male*	*$272.33*	*$272.33*
		Female	*$302.88*	*$302.88*
	15-20	*Male*	*$273.69*	*$273.69*
		Female	*$299.03*	*$299.03*
	21-44	*Male*	*$837.48*	*$708.46*
		Female	*$852.27*	*$720.98*
	45-64	*Male*	*$1,137.81*	*$962.52*
		Female	*$1,084.71*	*$917.60*
ACG-adjusted cells	*RAC10*	*Both*	*$208.50*	*$184.63*
ACG 100, 200, 300, 1100, 1300, 1400, 1500, 1600, 1710, 1720, 1730, 1900, 2400, 2600, 2900, 3400, 5110, 5200, 5310	*RAC11*	*Both*	*$311.79*	*$276.09*
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				
ACG 600, 1760, 3600, 3700, 4100, 4320, 4410, 4710, 4810, 4820	*RAC12*	*Both*	*$584.40*	*$517.48*
ACG 3800, 4210, 4220, 4330, 4420, 4720, 4910, 5320	*RAC13*	*Both*	*$656.26*	*$581.11*
ACG 800, 4430, 4510, 4610, 5040, 5340	*RAC14*	*Both*	*$905.49*	*$801.80*
ACG 1770, 4520, 4620, 4830, 4920, 5050	*RAC15*	*Both*	*$1,018.75*	*$902.09*
ACG 4730, 4930, 5010	*RAC16*	*Both*	*$1,309.53*	*$1,159.58*

Demographic Cells	*Age*	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
ACG 4940, 5020, 5060	*RAC17*	*Both*	*$1,828.01*	*$1,618.69*
ACG 5030, 5070	*RAC18*	*Both*	*$2,296.84*	*$2,033.83*
Persons with AIDS	*All*	*Both*	*$2,935.60*	*$2,659.43*
Persons with HIV	*All*	*Both*	*$1,655.85*	*$1,655.85*

(c) — (e) (text unchanged)

C. — D. (text unchanged)

.19-3 MCO Statewide Supplemental Payment.

A. (text unchanged)

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

(1) June [2002] *2003* payment:

(a) (text unchanged)

(b) The qualifications in §A of this regulation were met [as of April 1, 2002 and continue to be met through June 30, 2002;] *from January 1 through June 30, 2003; and*

(2) [September 2002] *December 2003* payments:

(a) (text unchanged)

(b) The qualifications in §A of this regulation were met [as of July 1, 2002, and continue to be met through September 30, 2002, and] *from July 1 through December 31, 2003.*

[(3) December 2002 payment:

(a) The MCO's Provider Agreement is current; and

(b) The qualifications in §A of this regulation were met as of October 1, 2002 and continue to be met through December 31, 2002.

C. The June 2002 payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in May 2002 prospectively for that MCO's June 2002 enrollment, multiplied by $12.26 per enrollee.

D.] *C.* The [September 2002] *June 2003* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in [August 2002] *May 2003* prospectively for that MCO's [September 2002] *June 2003* enrollment, multiplied by [$6.13] *$10.21* per enrollee.

[E.] *D.* The [December 2002] *December 2003* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in November [2002] *2003* prospectively for that MCO's December [2002] *2003* enrollment, multiplied by [$6.13] *$10.21* per enrollee.

.19-4 MCO Payment to Support HIPAA Compliance.

A. The Department shall, to the extent provided by this regulation, share a portion of the participating MCO's calendar year 2003 systems related costs for HIPAA compliance.

B. The Department shall make supplemental payments for calendar year 2003 expenses as required by this regulation by the end of June 2003 and December 2003.

C. An MCO shall provide DHMH with an outline of its 2003 business plan dealing with HIPAA compliance before the first semi-annual payment.

D. The MCO payment shall be computed as follows:

(1) June 2003 payment:

(a) Each MCO shall receive an equal share of $500,000; and

(b) The Department shall pay each MCO a share of $500,000 allocated by the percentage of the total MCO enrollees paid for in May 2003 prospectively for the June 2003 MCO enrollment; and

(2) December 2003 payment:

(a) Each MCO shall receive an equal share of $500,000; and

(b) The Department shall pay each MCO a share of $500,000 allocated by the percentage of the total MCO enrollees paid for in November 2003 prospectively for the total December 2003 MCO enrollment.

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

A. MCO Payment for Self-Referred Services.

(1) For undisputed claims that are submitted to the MCO within 6 months of the date of service, an MCO shall reimburse out-of-plan providers within 30 days for eligible services performed upon an enrollee who has self-referred:

(a) — (d) (text unchanged)

(e) For obstetric and gynecologic care provided to a pregnant woman, under the circumstances described in COMAR 10.09.67.28C; *and*

(f) For an initial medical examination of a newborn when the:

(i) (text unchanged)

(ii) MCO failed to provide for the service before the newborn's discharge from the hospital[; and

(g) For medical services such as physical therapy, occupational therapy, and speech therapy provided to a child under the circumstances described in COMAR 10.09.67.28H].

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

CPT code	Service Description
99201	Office visit, new patient, minimal
99202	Office visit, new patient, moderate
99203	Office visit, new patient, extended
99204	Office visit, new patient, comprehensive
99205	Office visit, new patient, complicated
CPT code	Service Description
99211	Office visit, established patient, minimal
99212	Office visit, established patient, moderate
99213	Office visit, established patient, extended
99214	Office visit, established patient, comprehensive
99215	Office visit, established patient, complicated
57170	Diaphragm fitting with instructions
58300	Insert intrauterine device
58301	Remove intrauterine device
99070	Special contraceptive supplies
[Y6841] *A4260*	Norplant contraceptive
11975	Insert contraceptive capsules
11976	Remove contraceptive capsules

CPT code	Service Description
11977	Removal with reinsertion of capsules
[Y6859] *J1055*	Depo-Provera-FP
00997	Latex condoms
[88150-5	PAP smear]
J1056	*Lunelle*
J7302	*Mirena*
J7300	*IUD-Copper*

(3) An MCO shall reimburse out-of-plan providers to whom enrollees have self-referred for an initial examination for a child in State-supervised care utilizing the [following] *Medicaid* payment schedule *for the following procedure codes*:

CPT code	Service Description
[W9081	Partial checkup
W9080	Comprehensive checkup]
Initial Comprehensive Preventive Medicine (New Patient)	
99381	*Infant (younger than 1 year old)*
99382	*Early childhood (1 — 4 years old)*
99383	*Late childhood (5 — 11 years old)*
99384	*Adolescent (12 — 17 years old)*
Periodic Comprehensive or Preventive Services (Established Patient)	
99391	*Infant (younger than 1 year old)*
99392	*Early childhood (1 — 4 years old)*
99393	*Late childhood (5 — 11 years old)*
99394	*Adolescent (12 — 17 years old)*

(4) — (9) (text unchanged)

[(10) An MCO shall reimburse out-of-plan specialty providers, such as physical therapy, occupational therapy, and speech therapy providers under the circumstances described in COMAR 10.09.67.28H at the following rates:

(a) For community-based providers at the MCO's in-network payment rates; and

(b) For institutional providers at the established Medicaid rates.

(11) The Department will reimburse out-of-plan Children's Medical Services community-based specialty providers, such as physical therapy, occupational therapy, and speech therapy providers, the difference between the rate paid by the MCOs pursuant to §H(10)(a) and (b) of this regulation and the established Medicaid rate for CMS community-based providers.]

B. (text unchanged)

.24 Enhanced Dental Services Plan.

A. — B. (text unchanged)

C. Funds Designated for Enhanced Dental Services.

(1) An MCO shall ensure that its enrollees who are younger than 21 years old receive enhanced dental services at a rate of use consistent with the targets set forth in §A(2) of this regulation[.] *; and*

(2) The Department shall pay supplemental payments for dental services for children younger than 21 years old when appropriate according to the following methodology:

(a) The Department shall divide the number of children in each MCO receiving dental services during calendar year 2003, as measured by encounter data submitted by June 30, 2004, by the average monthly enrollment of children younger than 21 years old in the MCO; and

(b) If the calculation in $C(2)(a) of this regulation exceeds 40 percent, the Department shall pay $113.53 times the number of children receiving dental services in excess of the 40 percent threshold, up to a maximum of 60 percent of the average monthly enrollment.

10.09.67 Maryland Medicaid Managed Care Program: Benefits

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

.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[, occupational therapy, and speech therapy] *for adult enrollees.*

.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) — (37) (text unchanged)

(38) Physical therapy, speech therapy, occupational therapy, and audiology services when:

(a) (text unchanged)

(b) The services are not part of *home health services or* an inpatient hospital stay;

(39) — (40) (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. — G. (text unchanged)

[H. Medical services directly related to a child's medical condition, such as physical therapy, occupational therapy, or speech therapy for a child with a special health care need who at the time of initial enrollment was receiving these services as part of a current plan of care, subject to the following requirements:

(1) The provider shall submit the plan of care to an MCO for review and approval within 30 days after the effective date of the child's enrollment in the MCO,

(2) The MCO shall continue to cover services delivered pursuant to the child's plan of care that was in effect on the effective date of enrollment until completion of its review,

(3) The MCO shall, after review and approval of the plan, allow recipients to continue to receive services from the provider selected by the enrollee before enrollment or from a provider approved by the MCO and accepted by the recipient if different from the provider of care before enrollment,

(4) The MCO shall provide any denial or reduction in the plan of care in writing to the child's specialty providers and the child's parent or guardian,

(5) The child's parent or guardian may initiate a complaint about the MCO's decision to deny or reduce services by calling the enrollee hotline which shall process the complaint and, if the complaint cannot be resolved to the satisfaction of the child's parent or guardian and the MCO, the Department may issue an order pursuant to COMAR 10.09.72,

(6) As appropriate, the Department may consult with external medical experts to evaluate the plan of care during the complaint resolution process,

(7) The enrollee or the MCO may appeal the Department's decision within 30 days from the date the enrollee receives the order, and

(8) The procedure described in COMAR 10.09.72.04, .05, and .06 governs the appeal and hearing process.]

10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System

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

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

.01 Scope.

This chapter outlines the Mental Hygiene Administration's (MHA) requirements for establishing the delivery system for specialty mental health services (SMHS) for waiver-eligible individuals, who are enrollees of managed care organizations (MCOs) or participants in the Rare and Expensive Case Management [(RECM)] *REM* program.

.02 Specialty Mental Health Services (SMHS) System Requirements.

A. — B. (text unchanged)

C. To implement the SMHS system, MHA shall:

(1) (text unchanged)

(2) To ensure appropriate and timely referrals from MCOs and the [RECM] *REM* program to the SMHS system, establish procedures, as outlined in Regulation .06 of this chapter that include:

(a) (text unchanged)

(b) Training and clinical guidance in appropriate use of the SMHS system for MCO primary care providers and [RECM] *REM* case managers, as outlined under Regulation .06C and D of this chapter,

(c) (text unchanged)

(d) Penalizing an MCO, or [RECM] *REM* program case manager, that demonstrates a pattern of improper referral.

D. MHA shall ensure that the SMHS system is a coordinated structure that:

(1) Coordinates an individual's mental health care with somatic care provided by the MCO or [RECM] *REM* program;

(2) (text unchanged)

(3) For a waiver-eligible individual who is diagnosed with substance abuse, is coordinated with the MCO or [RECM] *REM* program that provides substance abuse services to the individual;

(4) — (6) (text unchanged)

E. (text unchanged)

.05 Performance Standards.

A. (text unchanged)

B. Access to the SMHS System. To ensure that waiver-eligible individuals have appropriate and timely access to the SMHS, MHA shall:

(1) Establish a 24-hour per day, 7-day per week, toll-free telephone line for access to the SMHS system by:

(a) — (b) (text unchanged)

(c) MCOs and [RECM] *REM* program staff;

(2) In collaboration with MCOs and [RECM] *REM* program staff, coordinate:

(a) Referrals from MCOs and [RECM] *REM* to the SMHS system; and

(b) Substance abuse treatment with the waiver-eligible individual's MCO, or [RECM] *REM* case manager;

(3) — (6) (text unchanged)

(7) Ensure that SMHS are coordinated with:

(a) For general health care and necessary substance abuse treatment, the MCO or [RECM] *REM* program;

(b) — (c) (text unchanged)

C. — F. (text unchanged)

.07 Preauthorization.

A. — F. (text unchanged)

G. Denials.

(1) — (2) (text unchanged)

(3) Before denying any service, the SMHS UR agent, in collaboration with the MCO or [RECM] *REM* program and, if involved, the provider, shall determine whether an alternative service or a service of alternative duration is appropriate.

(4) (text unchanged)

(5) If the SMHS UR agent denies services, the SMHS UR agent shall notify, orally and in writing, the waiver-eligible individual, the MCO or [RECM] *REM* program, and, if involved, the provider, of the:

(a) — (c) (text unchanged)

(6) If, following a denial by the SMHS UR agent of a service requested by a provider, including an MCO or [RECM] *REM* program primary care provider, the provider makes a clinical determination that the service need is urgent and initiates services:

(a) — (b) (text unchanged)

(7) (text unchanged)

.08 Grievance Procedure and Appeal Right — Denial of Services.

A. General Provisions.

(1) — (2) (text unchanged)

(3) A provider, including an MCO or [RECM] *REM* program primary care provider who regards a service denial as inappropriate:

(a) — (b) (text unchanged)

B. — E. (text unchanged)

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

Subtitle 34 BOARD OF PHARMACY

10.34.26 Patient Safety Improvement

Authority: Health Occupations Article, §12-205(a)(3), Annotated Code of Maryland

Notice of Proposed Action

[01-399-P]

The Secretary of Health and Mental Hygiene proposes to adopt new Regulations .01 — .04 under a new chapter, **COMAR 10.34.26 Patient Safety Improvement.** Because substantive changes have been made to the original proposal as published in 28:25 Md. R. 2070 — 2071 (November 18, 2001), these regulations are being reproposed at this time. This action was considered by the Board of Pharmacy at a public meeting held June 19, 2002, notice of which was given by publication in 29:12 Md. R. 964 (June 14, 2002), pursuant to State Government Article, §10-506(c), Annotated Code of Maryland

Statement of Purpose

The purpose of this action is to create requirements for pharmacy permit holders to raise awareness of medication errors, to reduce such errors.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed regulation.