MEDICAL CARE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Parris N. Glendening
Governor

Martin P. Wasserman, M.D., J.D.
Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 7

December 30, 1998

Managed Care Organizations

FROM: Susan Tucker, Acting Director
Medical Care Policy Administration

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

RE: HealthChoice Regulation Amendments

The Secretary of Health and Mental Hygiene has adopted the following Proposed Amendments and new HealthChoice Regulations:

Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions; Regulations .01, .02, and .04 under COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment; Regulation .06 under COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application; Regulations .02, .03, .05, .08, .11, .11-1, .11-2, .15, .16, and .20, and new Regulations .24 and .25 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; Regulation .07 under COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access; Regulations .01, .04, .06, .07, .10, .13, .21, and .28 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits; Regulations .01, .02, .09, .10, and .14 under COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management and Stop Loss Case Management; Regulation .10 under COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System; and Regulations .01 - .03 under COMAR 10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures.

The proposed amendments were originally published in the July 31 and October 9, 1998 issues of the Maryland Register (Vol 25, Issues 16 and 21) and are attached to this transmittal. They become effective January 1, 1999.

Attachment

Description	Maximum Fee
Day of Personal Care (Agency) — Level 3	[25] *50*

(4) — (5) (text unchanged)

D. (text unchanged)

E. Payments to case monitoring agency providers shall be:

(1) (text unchanged)

(2) Made according to the following fee schedule for personal care case monitoring services:

Description	Maximum Fee
Month of case monitoring (Agency): Baltimore City	$[150] *215*
Baltimore County	[160] *200*
Montgomery County	[240] *290*
Prince George's County	[190] *255*
Other counties	[150] *185*

(3) (text unchanged)

MARTIN P. WASSERMAN, M.D.
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

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

Notice of Proposed Action

[98-275-P]

The Secretary of the Department of Health and Mental Hygiene proposes to amend Regulation .01 under **COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions**; Regulations .01, .02, and .04 under **COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment**; Regulation .06 under **COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application**; Regulations .02, .03, .05, .08, .11, .11-1, .11-2, .15, .16, and .20, and to adopt new Regulations .24 and .25 under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations**; Regulation .07 under **COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access**; Regulations .01, .04, .06, .07, .10, .13, .21, and .28 under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**; Regulations .01, .02, .09, .10, and .14 under **COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management and Stop Loss Case Management**; Regulation .10 under **COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System**; and Regulations .01 — .03 under **COMAR 10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures**, to become effective on January 1, 1999.

Statement of Purpose

The purpose of this action is to amend the regulations governing HealthChoice, the Maryland Medicaid Managed Care Program, and respond to changes prompted by the 1998 General Assembly's passage of several pieces of legislation affecting the Program. The amendments allow for continuation of the expansion of the Rare and Expensive Case Management Program, as well as the implementation for dental services for pregnant women and enhanced dental care for children.

The amended regulations strengthen the Department's ability to enforce outreach requirements consistent with the recently enacted HB922 and SB650. Also, the amended regulations implement SB38 by changing the definition of historic provider to include durable medical equipment providers licensed as residential service agencies.

The amendments address problems in the HealthChoice Program identified during the 1998 legislative session by the MCOs or various advocacy and recipient groups. Although not the product of legislation, the problems need immediate attention and these changes address the problems identified. They include: (1) the need to use a nationally recognized substance abuse assessment instrument, (2) the need to specify time frames for preauthorization and delivery of durable medical equipment and supplies approval and modification of time limits, and processes, (3) coverage of a newborn visit in the hospital by an out-of-network provider, (4) continuity of care provisions for special needs children receiving occupational, physical, and speech therapy when they enter an MCO, (5) the need to specify timelines for MCO response to provider complaints, (6) timelines for provision of encounter data; and (7) the need to streamline the Stop Loss Program.

Additionally, COMAR 10.09.69.10 is amended by deleting five optional services which are defined more appropriately as "long-term care". These services were originally included to provide services to the traumatic brain injured (TBI) population; however, this population is being removed from the REM Program while the Program drafts a request for a waiver from the Health Care Financing Administration for a special program for the TBI.

Finally, these amendments include various clean-up and nonsubstantive changes.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed regulation.

Estimate of Economic Impact

I. Summary of Economic Impact. The regulations add funding for enhanced dental services for children and dental care coverage for pregnant women, and require additional children to receive case management under the Rare and Expensive Case Management Program.

II. Types of Economic Impacts.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:		
(1) Dental	(E-)	$ 860,000
(2) REM	(E-)	1,000,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	**Magnitude**
D. On regulated industries or Trade groups:		
Managed care organizations	(+)	$ 860,000
E. On other industries or trade groups:		
Case management industry	(+)	$1,000,000
F. Direct and indirect effects on public:	NONE	

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

A. The fiscal impact includes an addition of $860,000 for the 6-month proposed period for improving access to dental services for

children and for providing dental coverage for pregnant women. In addition, the Department will be responsible for paying case management providers for the case management services required because of the expansion of the Rare and Expensive Case Management (REM) Program. This is estimated to cost the Department approximately $1,000,000, based on an addition of 800 REM patients at a cost of $1,250 per patient during the remainder of fiscal year 1999.

D. During the second half of FY '99, the managed care organizations will need to receive an increase of $860,000 in their capitation rates for dental improvements for children and dental coverage for pregnant women.

E. Case management providers will receive approximately $1,000,000 in additional funding for case managing 800 additional patients in the REM Program.

Economic Impact on Small Businesses

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

Opportunity for Public Comment

Comments on the proposed action may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, Room 538, 201 W. Preston Street, Baltimore, Maryland 21201, or call (410) 767-6499. These comments must be received by November 9, 1998.

Editor's Note: Except for new proposed amendments to Regulations .09 and .10 under COMAR 10.09.69, the text of this document will not be printed here because it appeared as a Notice of Emergency Action in 25:16 Md. R. 1261 — 1273 (July 31, 1998) referenced as [98-275-E]. Please note that this proposal does not include the amendments to Regulation .19 under COMAR 10.09.65, which were part of the original Emergency Action. The text of this proposal is otherwise unchanged.

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

.09 Covered Waiver Services — Assisted Living Services.

A. (text unchanged)

B. These services are rendered by a qualified individual as indicated below:

(1) — (2) (text unchanged)

[(3) Prevocational services pursuant to COMAR 10.22.12 and 10.22.13;]

[(4)] *(3)* — [(5)] *(4)* (text unchanged)

.10 Covered Waiver Services — Community Support.

A. (text unchanged)

B. The following services are covered:

[(1) Community supported living arrangement-type services, provided by a CSLA provider licensed by the Department;]

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

[(3) Day habilitation services which are:

(a) Provided by a day habilitation services provider licensed pursuant to COMAR 10.22.12 or 10.22.13;

(b) Furnished for 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care;

(c) Directed towards enabling the individual to attain the individual's maximum functional level; and

(d) Coordinated with any physical, occupational, or speech therapy listed in the plan of care;

(4) Residential habilitation services provided by a licensed provider pursuant to COMAR 10.22.03, subject to the limitation that payments may not be made:

(a) For room and board, the cost of facility maintenance, upkeep, and improvement, other than costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the requirements of the applicable life safety code;

(b) Directly or indirectly, to members of the recipient's immediate family;

(c) For the routine care and supervision which would be expected to be provided by a family or group home provider or for activities or supervision for which a payment is made by a source other than Medicaid;]

[(5)] *(2)* — [(6)] *(3)* (text unchanged)

[(7) Supported employment pursuant to COMAR 10.22.12 or 10.22.13 and these services:

(a) May be conducted in a variety of settings, particularly work sites in which persons without disabilities are employed;

(b) May include activities needed to sustain paid work by waiver participants, including supervision and training;

(c) May be reimbursed only for the adaptations, supervision, and training required by waiver participants as a result of their disabilities;

(d) Are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142;

(e) Are documented and maintained in the file of each individual receiving the services that the services are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142;

(f) Do not include payments, subsidies, or unrelated vocational training expenses such as the following:

(i) Incentive payments made to an employer of participants to encourage or subsidize employers' participation in a supported employment program,

(ii) Payments that are passed through to participants of supported employment programs,

(iii) Payments for vocational training that is not directly related to a participant's supported employment program, or

(iv) Payments for the supervisory activities rendered as a normal part of the business setting;]

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

MARTIN P. WASSERMAN, M.D.
Secretary of Health and Mental Hygiene

Subtitle 26 BOARD OF ACUPUNCTURE

10.26.02 General Regulations

Authority: Health Occupations Article, §1-211; [Agricultural] *Agriculture* Article, [§§2-301(e) and 2-304(e)] *§§2-301(g) and 2-304*; Annotated Code of Maryland

Notice of Proposed Action

[98-320-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation .06 under **COMAR 10.26.02 General Regulations**. This action was considered by the Board of Acupuncture at a public meeting held May 12, 1998, notice of which was given by publication in 25:9 Md. R. 710 (April 24, 1998), pursuant to State Government Article, §10-506(c), Annotated Code of Maryland.

For information concerning Emergency Action on Regulations, see inside front cover.

Symbol Key

Roman type indicates text existing before emergency status was granted. *Italic type* indicates new text. [Single brackets] indicate deleted text.

Emergency Regulations

Under State Government Article, §10-111(b), Annotated Code of Maryland, an agency may petition the Joint Standing Committee on Administrative, Executive, and Legislative Review (AELR), asking that the usual procedures for adopting regulations be set aside because emergency conditions exist. If the Committee approves the request, the regulations are given emergency status. Emergency status means that the regulations become effective immediately, or at a later time specified by the Committee. After the Committee has granted emergency status, the regulations are published in the next available issue of the Maryland Register. The approval of emergency status may be subject to one or more conditions, including a time limit. During the time the emergency status is in effect, the agency may adopt the regulations through the usual promulgation process. If the agency chooses not to adopt the regulations, the emergency status expires when the time limit on the emergency regulations ends. When emergency status expires, the text of the regulations reverts to its original language.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.03 Pharmacy Services

Au[illegible]: Health-General Article, §§2-104[illegible]-103, and 15-105
Annotated Code of M[illegible]and

No[illegible]e of Emer[illegible]cy Action
[98-[illegible]E]

The Joint Committee [illegible]ministrative, Executive, and Legislative Review has g[illegible] emergency status to amendments to Regulations [illegible], .0[illegible] and .07 under COMAR 10.09.03 Pharmacy [illegible]vices.

Emergency sta[illegible] began: July [illegible]1998.
Emergency st[illegible]s expires: Janua[illegible]1, 1999.

Editor's No[illegible]he text of this document will no[illegible]printed here beca[illegible] it appears as a Notice of Proposed A[illegible] on pages 1[illegible] — 1307 of this issue reference as [98-267-P]

MARTIN P. WASSERMAN, M. D.
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

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

Notice of Emergency Action
[98-275-E]

The Joint Committee on Administrative, Executive, and Legislative Review has granted emergency status to amendments to Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions; amendments to Regulations .01, .02, and .04 under COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment; amendments to Regulation .06 under COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application; amendments to Regulations .02, .03, .05, .08, .11, .11-1, .11-2, .15, .16, .19, and .20, and new Regulations .24 and .25 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; amendments to Regulation .07 under COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access; amendments to Regulations .01, .04, .06, .07, .10, .13, .21, and .28 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits; amendments to Regulations .01, .02, and .14 under COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management and Stop Loss Case Management; amendments to Regulation .10 under COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System; amendments to Regulations .01, .02, and .03 under COMAR 10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures.

Emergency status began: July 1, 1998.
Emergency status expires: January 1, 1999.

Comparison to Federal Standards

There is no corresponding federal standard to this emergency regulation.

Economic Impact on Small Businesses

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

July 14, 1998

Honorable Martin P. Wasserman, M.D., J.D.
Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Re: Approval of Emergency Regulation: Department of Health & Mental Hygiene: Medical Care Programs: COMAR 10.09.62—.67, .69, .70, and .72

Dear Secretary Wasserman:

Your Department's request for emergency status for the above-referenced regulations has been conditionally approved by the AELR Committee for the period beginning July 1, 1998 through January 1, 1999.

Pursuant to its authority under §10-111(b)(4) of the State Government Article, the Committee approves the regulations subject to the following conditions:

(1) On or before August 1, 1998, the Department shall submit revised MCO capitation rates for FY 1999 to the AELR Committee for approval by the Committee. For the service period beginning July 1, 1998, and until the FY 1999 rates become effective, the Department shall make capitation payments to MCOs which incorporate the Graduate Medical Education (GME) carve out amount and which are the monetary equivalent of the June, 1998 capitation payments to MCOs by increasing each Risk Adjustment Category (RAC) specified in COMAR 10.09.65.19D of the emergency regulations by the following amounts:

FAMILIES AND CHILDREN	ADJUSTMENTS
RAC 1	5.14
RAC 2	7.14
RAC 3	10.64
RAC 4	14.44
RAC 5	19.84
RAC 6	28.30
RAC 7	41.74
RAC 8	54.80
RAC 9	73.26
DISABLED	TOTAL DIFFERENCE
RAC 10	53.90
RAC 11	103.08
RAC 12	150.20
RAC 13	196.06
RAC 14	237.08
RAC 15	297.66
RAC 16	345.70
RAC 17	451.32
RAC 18	665.50
AIDS CITY	447.90
AIDS STATE	576.41

(2) For the service period beginning July 1, 1998, and until the FY 1999 rates become effective, the rate adjustment the Department makes to the RACs specified in COMAR 10.09.65.19E of the emergency regulations shall also apply to the rates for enrollees in the Children's Health Program.

(3) COMAR 10.09.65.05L(1) will read as follows [Committee modification underlined:]

L. (1) 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 service modality.

(4) COMAR 10.09.65.20A(10) and (11) will read as follows [Committee modification underlined]:

(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.

(5) The Department, under the auspices of the Mental Hygiene Administration, will apply in October of 1998 to the federal Health Care Financing Administration (HCFA) for a Community-based Waiver for individuals with traumatic brain injury. Pending federal approval of the Department's request for the waiver, the Department will ensure that individuals with traumatic brain injuries who would have met the eligibility criteria for the Rare and Expensive Case Management Program receive support services from the Mental Hygiene Administration. On approval by HCFA of the Department's waiver application, the Department will transfer these individuals into the waiver category based on criteria of medical necessity.

(6) The Department will work with Medicaid managed care organizations, Medicaid providers, Medicaid advocates, and the General Assembly to identify barriers to the receipt of timely encounter data and to prepare recommended options to remove those barriers for consideration during the 1999 session of the General Assembly.

(7) The Department will extend the age of eligibility of patients with cleft palate from 0—20 years under the Rare and Expensive Case Management Program.

(8) The Committee urges the Department to explore the feasibility of utilizing the nonemergency process for promulgating regulations relating to the capitation rates for the HealthChoice Program for Fiscal Year 2000 and subsequent fiscal years, including the possibility of altering the current date for commencement of the MCO contractual year.

Pursuant to §10-112(b) of the State Government Article, the Committee has filed two certified copies of these emergency regulations with the Administrator of the Division of State Documents for publication in the *Maryland Register*. The Administrator will acknowledge to you the receipt of these documents. Please note that the staff of the *Maryland Resister* will edit these regulations for style.

The Committee appreciates your continued cooperation.

Sincerely,
Christopher Van Hollen
Presiding Chairman

10.09.62 Maryland Medicaid Managed Care Program: Definitions

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) — (2) (text unchanged)

(2-1) "Addiction Severity Index (ASI)" means the nationally recognized substance abuse assessment instrument designed to detect and measure the severity of potential treatment problems for a patient, age 18 years old or older, in seven areas commonly affected by alcohol or drug dependence.

(3) — (8) (text unchanged)

(8-1) "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.

(9) — (64) (text unchanged)

(65) "Historic provider" means a health care provider, as defined in Health-General Article, §19-1501 *or a residential service agency, as defined in Health-General Article, §19-4A-01*, Annotated Code of Maryland, who, on or before June 30, 1995, had a demonstrated history of providing health care services to Program recipients and otherwise meets the requirements of COMAR 10.09.65.16.

(66) — (85) (text unchanged)

(85-1) "Long-term residential care program" (sometimes referred to as "group home" in the drug treatment field) means a facility, certified by the Department in accordance with COMAR 10.47.01, that provides extended substance abuse care for individuals who:

(a) Are 12 years old or older, but younger than 18 years old;

(b) Are ambulatory;

(c) Require a controlled environment and supportive therapy; and

(d) Do not require nursing, medical, or psychiatric care.

(86) — (87) (text unchanged)

(87-1) "Maryland Children's Health Program" means the State program for uninsured, low-income children with federal matching funds provided under Title XXI of the Social Security Act.

(88) — (124) (text unchanged)

(124-1) "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.

(125) — (137) (text unchanged)

(137-1) "Problem Oriented Screening Instrument for Teenagers (POSIT)" means the nationally recognized substance abuse assessment instrument designed to detect and measure the severity of a suspected or identified substance abuse problem of a patient, age 12 years old or older, but younger than 20 years old, through questions relating to 10 functional areas commonly affected by alcohol or drug dependence.

10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment

.01 Eligibility.

A. Criteria. Except as provided in §B of this regulation, a Program recipient shall be enrolled in the Maryland Medicaid Managed Care Program, described in this chapter, if the recipient is eligible for receipt of Medical Assistance benefits by qualifying:

(1) As categorically needy or medically needy under COMAR 10.09.24, unless the recipient is:

(a) — (b) (text unchanged)

(c) Otherwise certified for a period of less than 6 months; [or]

(2) For the Pregnant Women and Children's Program on or after January 1, 1997, unless the recipient enters the Program during the postpartum period; *or*

(3) For the Maryland Children's Health Program on or after July 1, 1998.

B. A recipient is not eligible for the Maryland Medicaid Managed Care Program if the recipient:

(1) — (3) (text unchanged)

(4) Is a child receiving adoption subsidy who is covered under the parent's private insurance; [or]

(5) Is a child under State supervision receiving adoption subsidy who lives outside of the State; *or*

(6) Is a child in an out-of-State placement.

C. Duration. A recipient eligible for the Maryland Medicaid Managed Care Program is guaranteed Medicaid eligibility for a period of 6 months from the initial effective date of each Medicaid eligibility period in any eligibility category, with the exception of:

(1) Pregnant women in the Pregnant Women and Children's Program, who are guaranteed eligibility for the duration of the pregnancy and 2 months postpartum; [and]

(2) Individuals who possess private health insurance or obtain health insurance through another source; *and*

(3) Inmates of a public institutions.

.02 Enrollment

A. — E. (text unchanged)

F. Recipient Selection of an MCO.

(1) (text unchanged)

(2) A recipient who is a child in foster care or kinship care shall have [30] *60* days from the date the Department mails its eligibility notification in which to select an MCO.

(3) — (4) (text unchanged)

G. (text unchanged)

H. Automatic Assignment Criteria.

(1) Children in Foster and Kinship Care. An eligible recipient who is a child in foster care or kinship care, and who fails to elect an MCO within [30] *60* days of the Department's mailing of eligibility notification shall be assigned to an MCO with available capacity in accordance with the procedures specified in §H(2) of this regulation.

(2) Except as provided in §H(1) of this regulation, an eligible recipient who fails to elect an MCO within 21 days of the Department's mailing of eligibility notification shall be assigned to a MCO with available capacity as follows:

(a) — (c) (text unchanged)

(d) If the recipient has a current preestablished relationship with a FQHC and is enrolled in a Medicaid HMO that has not qualified as an MCO, the recipient shall be assigned to an MCO in the local access area whose provider panel includes the FQHC; [or]

(e) [If] *Unless inconsistent with assigning household members to the same MCO pursuant to §H(2)(f) of this regulation, if* the recipient meets none of the conditions specified in §H(2)(a) — (d) of this regulation, [the recipient] *the Department* shall [be] randomly [assigned] *assign the recipient* to an MCO in the local access area that provides adult dental benefits, or, if there are none, then randomly to any MCO in the local access area; *or*

(f) If the recipient meets none of the conditions specified in §H(2)(a) — (d) of this regulation, the Department shall, in addition to assigning the recipient to an MCO pursuant to §H(2)(e) of this regulation, assign to the same MCO all the recipient's family members who:

(i) Are eligible for enrollment in the Maryland Medicaid Managed Care Program;

(ii) Live in the same household as the recipient; and

(iii) Meet none of the conditions specified in §H(2)(a) — (d) of this regulation.

I. — K. (text unchanged)

.04 Assignment to Primary Care Provider (PCP).

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

A. — B. (text unchanged)

10.09.64 Maryland Medicaid Managed Care Program: MCO Application

.06 Access and Capacity: Benefits and Appointments.

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

A. — M. (text unchanged)

N. A written description of the applicant's proposed member services unit, including a consumer services hotline, describing how the applicant will use this:

(1) — (2) (text unchanged);

(3) To facilitate enrollees' access to needed health care services, including how the hotline will function as a point of entry for complaint resolution and internal grievance procedures; *and*

O. A written Enrollee Outreach Plan that:

(1) Describes how the MCO intends to comply with the outreach, quality assurance, and provision of health care services requirements of Health-General Article, §15-103(b)(9), Annotated Code of Maryland; and

(2) To the extent that the materials are relevant to the requirements of §O(1) of this regulation, may incorporate by reference written materials provided by the applicant in response to other elements of its application.

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

.02 Conditions for Participation.

A. — F. (text unchanged)

G. Health Care Delivery. An MCO shall:

(1) — (2) (text unchanged)

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

(a) — (c) (text unchanged)

(4) (text unchanged)

H. — U. (text unchanged)

.03 Quality Assurance and Improvement Systems.

A. — O. (text unchanged)

P. An MCO shall submit a corrective action plan *required* as a result of the annual audit *or the drug use management program and formulary review* as follows:

(1) Within 45 days of receiving the results of the annual audit *or the drug use management program and formulary review*, the MCO shall submit for the Department's approval a plan detailing a corrective course of action to rectify any deficiencies identified in the audit *or review* resulting in a compliance rating below the rating established for that year in any element of the systems performance review, [or] the clinical care review, *or the drug use management program and formulary program review*; and

(2) At the Department's request, the MCO shall participate in any re-review by the Department of the deficiencies identified during the audit *or review* to ensure implementation of all corrective action.

Q. — S. (text unchanged)

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

A. — J. (text unchanged)

K. The Department shall continue the current system of payment from Children's Medical Services (CMS) for wrap-around services, including disease management services, for Medicaid recipients at least until January 1, 1999, and until a 90-day notice of the implementation of the CMS redesign initiative has been released.

L. 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 speciality 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) If the MCO denies the request for an out-of-network provider referral, the child's parent or guardian may initiate the complaint and appeal process set forth at COMAR 10.09.72;

(2) If at any time the MCO decides to terminate or reduce services provided by the approved out-of-network provider, the child's parent or guardian may initiate the complaint and appeal process set forth at COMAR 10.09.72

(3) The MCO shall continue to cover the services of the out-of-network provider during the course of the appeal until such time as the Office of Administrative Hearings issues its decision.

.08 Special Needs Populations—Pregnant and Postpartum Women

A. — L. (text unchanged)

M. An MCO shall provide dental services for pregnant enrollees in accordance with COMAR 10.09.67.06.

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

A. — D. (text unchanged)

E. When the substance abuse screening described in §[illegible] of this regulation confirms the probability of substance abuse [and the need for treatment], the MCO shall provide the enrollee with [a]*:*

(1) A comprehensive substance abuse assessment which shall:

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

(b) Include application of one of the following assessment instruments, as appropriate:

(i) For enrollees younger than 20 years old, the Problem Oriented Screening Instrument for Teenagers (POSIT), and

(ii) For enrollees 20 years old or older, the Addiction Severity Index (ASI); and

(2) [Lead to a determination of the appropriate level and intensity of care, based on whether the enrollee:

(a) Has acute intoxication and will likely have withdrawal symptoms.

(b) Is treatment resistant and will likely deny the need for treatment.

(c) Has coexisting physical or psychiatric diagnoses or

(d) Is likely to relapse due to psychological factors or environmental pressures.] *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.*

F. Based on [the results of] the *comprehensive* substance abuse assessment [performed under] *and placement appraisal as specified in* §E of this regulation, the MCO shall refer the enrollee to a provider that is qualified to provide the service based on the criteria set forth in §H of this regulation.

G. — H. (text unchanged)

I. [The] *An* MCO may not deny an enrollee access to substance abuse treatment services solely on the basis of preexisting alcohol or other drug treatment experiences.

.11-1 Substance Abuse Identification and Treatment — TCA Recipients — Notification Requirements.

A. — C. (text unchanged)

D. Notification. When PCP is Responsible for Direct Referral for Substance Abuse Treatment.

(1) This section applies if the comprehensive substance abuse assessment *and placement appraisal* required by Regulation .11E of this chapter is provided by:

(a) (text unchanged)

(b) A comprehensive substance abuse assessment *and placement appraisal* provider who does not directly refer the enrollee for treatment, but reports the results of the assessment *and appraisal* to the enrollee's PCP.

(2) In the circumstances described in §D(1) of this regulation, the MCO shall notify, or ensure that the enrollee's PCP notifies, the enrollee's local department of social services when any of the following occurs:

(a) The enrollee fails to appear for or fails to complete a comprehensive substance abuse assessment *and placement appraisal* ordered by the enrollee's PCP in accordance with Regulation .11E of this chapter;

(b) — (c) (text unchanged)

E. *Treatment Referral* Notification [by Assessment Provider with Authority to Make Treatment Referral] *by Comprehensive Assessment and Placement Appraisal Provider.*

(1) This section applies when the comprehensive substance abuse assessment *and placement appraisal* required by Regulation .11E of this chapter is provided by a comprehensive substance abuse assessment *and placement appraisal* provider who is authorized to directly refer the enrollee for appropriate substance abuse treatment.

(2) The MCO shall notify, or ensure that the enrollee's PCP notifies, the enrollee's local department of social services when the PCP refers the enrollee for a comprehensive substance abuse assessment *and placement appraisal.*

(3) The comprehensive substance abuse assessment *and placement appraisal* provider shall notify the enrollee's local department of social services when any of the following occurs:

(a) The enrollee fails to appear for or fails to complete a comprehensive substance abuse assessment *and placement appraisal* ordered by the enrollee's PCP in accordance with Regulation .11E of this chapter.

(b) (text unchanged)

(c) The comprehensive substance abuse assessment *and placement appraisal* provider refers the enrollee for appropriate substance abuse treatment.

F. — H. (text unchanged)

.11-2 Substance Abuse Identification and Treatment — TCA Recipients — Notification, Consent Forms, and Liaison.

A. — D. (text unchanged)

E. Transferring Duplicate Originals of Enrollee's Consent.

(1) — (3) (text unchanged)

(4) At the time a referral is made pursuant to Regulation .11-1E(2) of this chapter, an MCO shall transfer, or ensure that its PCP transfers, at least two copies of the carbonized consent form described in §A of this regulation to the comprehensive substance abuse assessment *and placement appraisal* provider to whom the enrollee is referred.

(5) At the time a referral is made pursuant to Regulation .11-1E(3) of this chapter, the comprehensive assessment *and placement appraisal* provider shall transfer at least one copy of the carbonized consent form described in §A of this regulation to the substance abuse treatment provider to whom the enrollee is referred.

F. — G. (text unchanged)

.15 Data Collection and Reporting.

A. (text unchanged)

B. Encounter Data.

(1) (text unchanged)

(2) An MCO shall report encounter data within [90] *60* calendar days after [the last day of the month within which the encounter occurred] *receipt of the claim from the provider.*

(3) — (4) (text unchanged)

C. — J. (text unchanged)

.16 Historic Providers.

A. Conditions of Eligibility.

(1) A health care provider *or residential service agency* is an historic provider if the provider *or agency* meets the:

(a) Definition of ["health]:

(i) "Health care provider" set forth in Health-General Article, §19-1501(d), Annotated Code of Maryland, or

(ii) "Residential service agency" as defined in Health-General Article, §19-4A-01, Annotated Code of Maryland; and

(b) (text unchanged)

(2) (text unchanged)

(3) A provider [who] *or residential service agency that* is not a PMP has a demonstrated history of providing health care services to Program recipients if the provider *or residential service agency* has, between July 1, 1994, and June 30, 1995:

(a) — (b) (text unchanged)

(4) A provider *or residential service agency* has a demonstrated history of providing health care services to Program recipients if the provider *or residential service agency* has, during any calendar year between 1991 and 1994, inclusive, had a practice consisting of at least 5 percent Program recipients.

(5) (text unchanged)

B. Certification and Assignment.

(1) — (2) (text unchanged)

(3) With the petition, the historic provider shall submit evidence [that] *of:*

(a) [The provider's qualifications meet] *Qualifications meeting* the requirements of §A of this regulation; and

(b) [The provider has applied] *Application* to every MCO or MCO applicant serving or proposing to serve the provider's service area and, at the time of filing the petition,

with respect to each MCO and MCO applicant contacted. [the provider has received] *receipt of*:

(i) — (iii) (text unchanged)

(4) The Department shall review the [provider's] *historic provider applicant's* qualifications to determine whether the requirements of §A of this regulation are met. If the Department determines that the *historic* provider *applicant*:

(a) Does not qualify as an historic provider meeting the quality standards for *Maryland* Medicaid Managed Care Program participation, the Department shall:

(i) Provide written notice [to the provider] of the deficiencies, and, if appropriate, afford the *historic* provider *applicant* an opportunity to correct them, and

(ii) If the *historic* provider *applicant* is unable or unwilling to correct identified deficiencies, issue written notification of its final determination rejecting the [provider's] petition for certification as an historic provider; or

(b) Qualifies as an historic provider who meets the quality standards for *Maryland* Medicaid Managed Care Program participation, the Department shall certify the *historic* provider *applicant* as an "historic provider" eligible for mandatory assignment to an MCO.

(5) — (6) (text unchanged)

C. (text unchanged)

D. MCO—Required Documentation and Disclosures.

(1) When requested by the Department or by the a[illegible] signed historic provider, an MCO shall:

(a) Provide documentary evidence of qualificatic[illegible] differences to substantiate contractual arrangement[illegible] ing between [providers] *the assigned historic provid[illegible] ar[illegible] other MCO subcontractors of the same practice type*; ar[illegible]

(b) Provide a written description of [its provider] r[illegible] muneration arrangements *between the MCO and its subco[illegible] tractors of the same practice type as the assigned histor[illegible] provider*.

(2) (text unchanged)

.19 MCO Reimbursement.

A. (text unchanged)

B. Capitation Rate-Setting Methodology.

(1) — (3) (text unchanged)

(4) [The] *Except as modified by §D of this regulatio[illegible] the* Department shall make capitation payments monthly [illegible] the rates specified in the following tables:

(a) — (e) (text unchanged)

(5) (text unchanged)

C. (text unchanged)

D. For the service period beginning July 1, 1998, and [illegible] set forth in §E of this regulation, the rates, based on t[illegible] "ACG — Case Mix Adjustment System Version 4.0", shall [illegible] as follows:

(1) Rate Table for Families and Children.

Families / Children	*MAPCC (base rate)*		*$109.56*	
	Age	*Gender*	*PMPM Baltimore City*	*PMP[illegible] Rest [illegible] Stat[illegible]*
Demographic Cells				
	Under Age 1	*Both*	*$351.31*	[illegible]*4.*[illegible]
	1 — 5	*Male*	*$87.23*	[illegible]*65.*[illegible]
		Female	*$70.23*	*$53.*[illegible]
	6 14	*Male*	*$78.76*	*$63.*[illegible]
		Female	*$59.92*	*$47.*[illegible]
	15 20	*Male*	*$144.25*	*$95.*[illegible]
		Female	*$156.72*	*$103.*[illegible]
	21 44	*Male*	*$175.87*	*$152.*[illegible]
		Female	*$204.77*	*$129.*[illegible]
	45 +	*Male*	*$365.01*	*$314.*[illegible]
		Female	*$303.91*	*$205.*[illegible]
ACG-adjusted Cells				
ACG 100, 200, 300, 500, 600, 1100, 1600, 2000, 2400, 3400, 5110, 5200	*RAC1*	*Both*	*$47.61*	*$47.*[illegible]
ACG400, 700, 900, 1000, 1200, 1300, 1710, 1800, 1900, 2100, 2200, 2300, 2800, 2900, 3000, 3100, 5310	*RAC2*	*Both*	*$66.29*	*$66.*[illegible]
ACG1720, 1730, 2500, 3200, 3300, 3500, 3800, 4210, 5320, 5330	*RAC3*	*Both*	*$98.66*	*$98.*[illegible]
ACG800, 1740, 1750, 2700, 3600, 3700, 3900, 4000, 4100, 4220, 4310, 4410, 4510, 4610, 4710, 4720, 4810, 5340	*RAC4*	*Both*	*$133.96*	*$133.*[illegible]
ACG1400, 1500, 1760, 1770, 2600, 4320, 4520, 4620, 4820	*RAC 5*	*Both*	*$184.13*	*$184.*[illegible]
ACG4330, 4420, 4830, 4910, 4920, 5010, 5020, 5040	*RAC 6*	*Both*	*$262.91*	*$262.*[illegible]
ACG4430, 4730, 4930, 5030, 5050	*RAC 7*	*Both*	*$387.71*	*$387.*[illegible]
ACG4940, 5060	*RAC 8*	*Both*	*$508.95*	[illegible]*508.*[illegible]

	Age	Gender	PMPM Baltimore City	PMPM Rest of State
ACG5070	RAC 9	Both	$680.36	$680.36
PWC (SOBRA) Mothers			$363.98	$216.25
Maternity/Delivery		MAPCC		$3,835.47
(base rate)				
(supplemental payment per delivery)			$4,187.83	$3,717.78

(2) Rate Table for Disabled Individuals.

	Age	Gender	PMPM Baltimore City	PMPM Rest of State
Disabled	MAPCC (base rate)		$421.84	
Demographic Cells	Under Age 1	Both	$1,496.62	$1,496.62
	1 — 5	Male	$608.25	$608.25
		Female	$590.58	$590.58
	6 — 14	Male	$358.05	$358.05
		Female	$429.57	$429.57
	15 — 20	Male	$266.40	$266.40
		Female	$289.49	$289.49
	21 — 44	Male	$577.50	$375.57
		Female	$631.30	$361.20
	45 +	Male	$662.54	$560.82
		Female	$673.53	$478.54
ACG-adjusted Cells				
ACG 100, 200, 300, 110, 1300, 1400, 1500, 1600, 1710, 1720, 1730, 1900, 2400, 2600, 2900, 3400, 5110, 5200, 5310	RAC 10	Both	$112.93	$112.93
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	RAC 11	Both	$215.90	$215.90
ACG 600, 1760, 3600, 3700, 4100, 4320, 4410, 4710, 4810, 4820	RAC 12	Both	$314.61	$314.61
ACG 3800, 4210, 4220, 4330, 4420, 4720, 4910, 5320	RAC 13	Both	$410.71	$410.71
ACG 800, 4430, 4510, 4610, 5040, 5340			$496.61	$496.61
ACG 1770, 4520, 4620, 4830, 4920, 5050			$623.50	$623.50
ACG 4730, 4930, 5010			$724.17	$724.17
ACG 4940, 5020, 5060			$945.34	$945.34
ACG 5030, 5070			$1,394.00	$1,394.00
Persons with AIDS				$1,533.65
			$1,683.03	$1,235.76

Adjustments		Total Difference
	RAC 8	54.80
	RAC 9	73.26
	Disabled	Total Difference
	RAC 10	53.90
	RAC 11	103.08
	RAC 12	150.20
	RAC 13	196.06
Adjustments	RAC 14	237.08
5.14	RAC 15	297.66
7.14	RAC 16	345.70
10.64	RAC 17	451.32
14.44	RAC 18	665.50
19.84		
28.30	AIDS City	447.90
41.74	AIDS State	576.41

.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) — (c) (text unchanged)

(d) For one annual diagnostic and evaluation service visit for an enrollee diagnosed with human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS) pursuant to COMAR 10.09.67.28E; [and]

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

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

(i) Examination is performed in a hospital by an on-call physician, and

(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) — (8) (text unchanged)

(9) An MCO shall reimburse out-of-plan providers under the circumstances described in COMAR 10.09.67.28G at a rate not less than the fee-for-service Medicaid rate for an initial medical examination of a newborn when the mother's MCO fails to provide for the service before the newborn is discharged from the hospital.

(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. Each year, an MCO shall develop and implement an Enhanced Dental Services Plan that includes a description of how the MCO intends to:

(1) Provide enhanced dental services to enrollees younger than 21 years old; and

(2) Increase utilization of dental services by its enrollees.

B. On or before July 1 of each year, an MCO shall submit its Enhanced Dental Services Plan to the Department for its approval.

C. Funds Designated for Enhanced Dental Services.

(1) A portion of the Department's capitation payments to each MCO are supplemental monies that are designated for enhanced dental services for enrollees younger than 21 years old.

(2) An MCO may not make expenditures from the designated funds referenced in §C(1) of this regulation that are inconsistent with the MCO's Enhanced Dental Services Plan that has been approved by the Department.

(3) An MCO shall make no expenditures from the designated funds referenced in §C(1) of this regulation unless the expenditures are:

(a) For providing enhanced dental services for enrollees younger than 21 years old;

(b) To increase utilization of dental services by its enrollees younger than 21 years old; or

(c) To provide incentives to increase provider participation.

.25 Enrollee Outreach Plan.

A. An MCO shall submit to the Department, on an annual basis, a written Enrollee Outreach Plan that:

(1) Describes how the MCO intends to comply, in the upcoming year, with the outreach requirements of Health-General Article, §15-103(b)(9), Annotated Code of Maryland; and

(2) Provides evidence of the MCO's compliance during the previous year, with the outreach requirements of Health-General Article, §15-103(b)(9), Annotated Code of Maryland.

B. Submission Date

(1) An MCO applicant shall submit its initial Enrollee Outreach Plan, as part of its MCO application, as required by COMAR 10.09.64.06O.

(2) An MCO shall submit by January 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

.07 Access Standards: Clinical and Pharmacy Access.

A. (text unchanged)

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

(1) (text unchanged)

(2) An MCO representative may not leave an enrollee's telephone call on hold for more than 10 minutes; [and]

(3) An MCO representative shall respond to patient inquiries as to whether or not to use emergency facilities within 30 minutes[.];

(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, but not later than 72 hours after the initial request; and

(5) MCOs shall notify the provider in writing whenever the provider's request for preauthorization for a service is denied.

C. Hours of Access for Clinical Services.

(1) (text unchanged)

(2) Hours of Access for Pharmacy Services.

(a) — (c) (text unchanged)

(d) Except as permitted in §C(2)(e) of this regulation an MCO shall ensure that an enrollee receives at the time the prescription is dispensed to the enrollee any medically necessary disposable medical supplies or durable medical equipment needed by the enrollee to administer or monitor the enrollee's prescriptions.

(e) An MCO shall ensure that any disposable supplies or durable medical equipment necessary to administer or monitor an enrollee's prescriptions, if not available at the pharmacy at the time of the dispensing of the prescription, received in a manner so as not to adversely effect the health of the enrollee, but not later than 24 hours.

D. — E. (text unchanged)

10.09.67 Maryland Medicaid Managed Care Program: Benefits

.01 Required Benefits Package — In General.

A. — C. (text unchanged)

D. Interpretation. [Except for the exclusion of the services specified in Regulation .27B(5) — (11), (27), and (29) of this chapter, which are not the MCO's responsibility in the Maryland Medicaid Managed Care Program, this] *This* chapter is intended to describe a baseline benefits package for MCOs that is equivalent to Medicaid benefits available as of January 1, 1996, under Maryland's Medicaid fee-for-service system, *except as follows:*

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

(2) Regulation .06B of this chapter adds a benefit that traditionally has not been covered by Maryland's Medicaid fee-for-service program, but is the MCO's responsibility in the Maryland Medicaid Managed Care Program.

E. (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) — (9) (text unchanged)

(10) Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for an enrollee by a qualifying provider as specified in §B of this regulation;

[(10)] *(11)* — [(11)] *(12)* (text unchanged)

B. — E. (text unchanged)

F. An MCO shall:

(1) Establish and maintain a drug use management program; and

(2) Adhere to the minimum performance standards established by the Department for these programs, whenever used, including but not limited to standards for the following drug use management components:

(a) Formulary management,

(b) Generic substitution,

(c) Therapeutic substitution,

(d) Prior authorization,

(e) Drug use evaluation (DUE),

(f) Disease management, and

(g) Pharmacy and Therapeutic Committee.

.06 Dental Services [for Children].

A. An MCO shall provide medically necessary and appropriate dental services for its enrollees who are younger than 21 years old, including but not limited to:

[A.] *(1)* — [B.] *(2)* (text unchanged)

[C.] *(3)* Pit and fissure sealants for the occlusal surfaces of posterior permanent teeth that are without restoration or decay; [and]

[D.] *(4)* Orthodontic care when the condition causes dysfunction and the case scores at least 15 points on the Handicapping Labio-Lingual Deviations Index No. 4[.]*; and*

(5) General anesthesia during dental procedures when it is medically necessary and appropriate.

B. An MCO shall provide to pregnant enrollees, who are 21 years old or older, diagnostic, emergency, preventive, and therapeutic dental services for oral diseases, including but not limited to:

(1) Emergency, preventative, diagnostic, and treatment services;

(2) One cleaning, fluoride treatment, and examination; and

(3) Pit and fissure sealants for the occlusal services of posterior permanent teeth that are without restoration or decay.

.07 Benefits — Inpatient Hospital Services.

A. (text unchanged)

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) The first 30 continuous days following the enrollee's admission; and

(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) Acute care services provided within the first 30 days following an enrollee's admission to a long-term care facility does not constitute a break in calculating the 30 continuous day requirement if the enrollee is discharged from the hospital back to the long-term care facility.

C. — F. (text unchanged)

.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] *10.09.65.11 — .11-2*, including but not limited to:

(1)[A comprehensive substance abuse assessment] *Evaluations*, performed by a provider that is qualified under §B of this regulation, [which leads to a determination of] *to determine the nature and severity of an enrollee's substance abuse problem and* the appropriate level and intensity of care[;]*, including:*

(a) A comprehensive substance abuse assessment using either the ASI or POSIT assessment instrument, as appropriate, and

(b) A placement appraisal which, as of October 1, 1998, shall be one using the ASAM PPC-2 placement criteria;

(2) — (6) (text unchanged)

B. (text unchanged)

C. Referrals of TCA Recipients who are 21 Years Old or Older for Residential Substance Abuse Treatment Services.

(1) In addition to providing the substance abuse treatment services described in §§A and B of this regulation, an MCO also has the responsibility of making appropriate referrals [for]*:*

(a) For TCA recipients who are 21 years old or older for the following treatment modalities:

[(a)] *(i)* Intermediate care substance abuse treatment in an Intermediate Care Facility — Alcoholic (ICF-A)[;]*,* and

[(b)] *(ii)* Substance abuse treatment in a halfway house or residential drug-free treatment program[.]*;*

(b) For TCA recipients who are 18 through 20 years old and are parents, substance abuse treatment in a halfway house or residential drug-free treatment program; and

(c) For TCA recipients who are younger than 18 years old and are parents, substance abuse treatment in a long-term residential care program.

(2) The Department shall provide reimbursement directly to the provider, on a fee-for-service basis, for services provided pursuant to this section to TCA recipients who [are 21 years old or older] *meet the eligibility criteria set forth in this section.*

.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: [incontinency pants and disposable underpads for medical conditions associated with prolonged urinary or bowel incontinence if necessary to prevent institutionalization or infection.]

(1) All supplies and equipment used in the administration or monitoring of prescriptions by the enrollees; and

(2) Incontinency pants and disposable underpads for medical conditions associated with prolonged urinary or bowel incontinence if necessary to prevent institutionalization or infection.

B. Except as required in §C(1), an MCO shall provide preauthorization within 72 hours for DMS/DME services and supplies that require preauthorization by the MCO.

C. An MCO shall provide its enrollees the disposable medical supplies and durable medical equipment in a timely manner so as to not adversely affect the health of the enrollees, in accordance with the following:

(1) For medical equipment or supplies, or both, when there is an urgent medical need such as to facilitate hospital discharge or when a potential exists for worsening of enrollee's condition, the MCO shall provide needed items within 24 hours of request; and

(2) For all other requests for DMS/DME, the MCO shall provide these items within 7 days from the date of request unless the MCO can document to the Department that justification for additional time is necessary.

.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) — (d) (text unchanged)

(e) High-risk nutrition counseling services for nutritionally high-risk pregnant women; [and]

(f) Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers[.]; *and*

(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. — D. (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. — D. (text unchanged)

E. One annual diagnostic and evaluation service (DES) visit for any enrollee diagnosed with HIV/AIDS, which the MCO is responsible for facilitating on the enrollee's beh[alf]; [and]

F. Renal dialysis services performed in a [Medicare] certified facility[.];

G. Initial medical examination of a newborn when [the]:

(1) Examination is performed in a hospital by an [on-]call physician, and

(2) MCO failed to provide for the service before the n[ew]born's discharge from the hospital; and

H. Medical services directly related to a child's med[ical] condition, such as physical therapy, occupational therapy[, or] speech therapy for a child with a special health care n[eed] who at the time of initial enrollment was receiving these s[er]vices as part of a current plan of care, subject to the foll[ow]ing requirements:

(1) The provider shall submit the plan of care to [the] MCO for review and approval within 30 days after the eff[ec]tive date of the child's enrollment in the MCO;

(2) The MCO shall continue to cover services deliver[ed] pursuant to the child's plan of care that was in effect on [the] effective date of enrollment until completion of its revi[ew];

(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 fro[m a] provider approved by the MCO and accepted by the recip[ient] if different from the provider of care before enrollment;

(4) The MCO shall provide any denial or reduction [of] the plan of care in writing to the child's specialty provid[er] and the child's parent or guardian;

(5) The child's parent or guardian may initiate a co[m]plaint about the MCO's decision to deny or reduce services [by] calling the Enrollee Hotline which shall process the co[m]plaint and, if the complaint cannot be resolved to the sat[is]faction of the child's parent or guardian and the [MCO], t[he] Department may issue an order pursuant to [CO]M[AR] 10.09.72;

(6) As appropriate, the Department may consult w[ith] external medical experts to evaluate the plan of care duri[ng] the complaint resolution process;

(7) The enrollee or the MCO may appeal the Depa[rt]ment's decision within 30 days from the date the enrollee [re]ceives the order; and

(8) The procedure described in COMAR 10.09.72.[04], .05, and .06 governs the appeal and hearing process.

10.09.69 Maryland Medicaid Managed Ca[re] Program: Rare and Expensive Case Manag[e]ment and Stop Loss Case Management

.01 Rare and Expensive Case Management (RE[M]).

A. (text unchanged)

B. [Eligibility for REM.]

[(1) Except as provided in §B(2) of this regulation, a] Program recipient shall be enrolled in the program if t[he] recipient has one or more of the diagnoses specified in [§ ...] *§L* of this regulation.

[(2) A Program recipient younger than 22 years [old] who qualifies for the Model Waiver Program may be dis[en]rolled from the Maryland Medicaid Managed Care Progr[am] and enrolled in the Model Waiver program, as long as the[re] are available slots in the Model Waiver program.]

C. (text unchanged)

D. An individual participating in REM shall be assign[ed] to a REM case manager, who shall:

(1) Gather all relevant information needed to determine the participant's condition and needs, including the participant's medical records;

(2) Consult with the participant's current service providers;

(3) Evaluate the relevant information and complete a needs analysis, including medical, psychosocial, environmental, and functional assessments;

[(2)] *(4)* [Assign] *Assist* the REM participant, offering the participant a choice, if possible, [of] *in selecting and obtaining* an appropriate primary care provider, who may be a specialist as appropriate to the condition, giving preference to any preestablished relationships between the participant and a primary care provider *and for participants younger than 21 years old, ensuring that the individual receives EPSDT services as specified in COMAR 10.09.67.20*; [and]

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

[(3)] *(6)* [Authorize services that the REM participant is to receive.] *Implement the plan of care and assist the participant in gaining access to medically necessary and appropriate services by linking to those services and assuring that recommended services are rendered;*

(7) Monitor service delivery, perform record reviews, and maintain contacts with the participant, service providers, and family members to evaluate the participant's condition and progress and to determine whether revision is needed in the plan of care or in service delivery;

(8) As necessary, initiate and implement plan modifications and communicate any changes in the plan of care to the participant, parents or guardians, and pertinent health care providers;

(9) At the request of the local lead agency, provide early intervention service coordination, as described in COMAR 10.09.40, for infants and toddlers participating in local infants and toddlers programs under COMAR 13A.13.01; and

(10) Coordinate school health-related services with the local education agency responsible for implementing a child's individualized education program as described in COMAR 10.09.50 for a participant who meets the eligibility criteria for this program.

E. Benefits. As determined medically necessary and appropriate [by the case manager], an REM participant is eligible for:

(1) — (2) (text unchanged)

F. — G. (text unchanged)

H. (repealed)

H. Not later than 100 days from the date an individual becomes ineligible for REM as a result of changes in the diagnosis or age group criteria specified in §L of this regulation, the individual shall select and be enrolled in an MCO.

I. An individual eligible for REM may elect to enroll in an MCO by notifying the Department in writing of the election.

J. An individual who becomes eligible for REM while enrolled in an MCO may elect to remain in the MCO by notifying the Department in writing of the election.

K. When an REM-eligible individual elects to remain in an MCO, the Department, in consultation with the MCO and the REM-eligible individual, may determine whether the MCO can appropriately meet the individual's medical needs within the parameter of the HealthChoice benefit package as described in COMAR 10.09.67.

L. If the Department determines that the MCO cannot appropriately meet the individual's medical needs, it shall issue a written determination to the individual and the MCO, which includes:

(1) The reason for its determination; and

(2) An explanation of the individual's right to appeal the determination according to the procedures set forth in COMAR 10.09.72.

M. The Department shall allow an individual who immediately before enrollment in REM was receiving medical services from a specialty clinic or other setting to continue to receive services in that setting upon enrollment in the REM program.

N. An individual eligible for REM who has elected to enroll in an MCO or to remain enrolled in an MCO is not eligible to receive REM services under the REM program.

O. Table of Rare and Expensive Conditions

Condition Type	*Diagnosis*	*ICD9 Codes*	*Age Grp*
HIV	*Symptomatic HIV/AIDS (pediatric)*	*042.x all*	*0 — 20*
Disease	*Asymptomatic HIV status (pediatric)*	*V08*	*0 — 20*
	Inconclusive HIV Result (Infant)	*795.71*	*0 — 12 mo*
Metabolic	*Disturbances of amino-acid transport*	*270.0*	*0 — 20*
	PKU, MSUD, other amino acid metabolism	*270.1 thru 270.4*	*0 — 20*
	Disturbances of histidine metabolism	*270.5*	*0 — 20*
	Disorders of Urea cycle metabolism	*270.6*	*0 — 20*
	Amino acid metabolism disorders	*270.7, 270.8*	*0 — 20*
	Glycogenesis, galactosemia, fructose intolerance	*271.0, 271.1, 271.2*	*0 — 20*
	Lipidoses	*272.7*	*0 — 20*
	Cystic Fibrosis	*277.0, .00, .01*	*0 — 64*
	Purine/Pyrimidine disorders	*277.2*	*0 — 64*
	Mucopolysaccharidosis	*277.5*	*0 — 64*
	Histiocytosis	*277.8*	*0 — 64*
Blood	*Aplastic Anemia, constitutional*	*284.0*	*0 — 20*
	Hemophilia	*286.0 thru 286.4*	*0 — 64*
Degenerative	*Cerebral degen. disease of childhood*	*330.x, all 4th digits*	*0 — 20*
	Communicating and Obstructive Hydrocephalus	*331.3, 331.4*	*0 — 20*
Diseases	*Extrapyramidal degen. — myoclonus*	*333.2*	*0 — 5*
	Idiopathic torsion dystonia	*333.6*	*0 — 64*

Condition Type	Diagnosis	ICD9 Codes	Age Grp
	Symptomatic torsion dystonia	333.7	0—64
	Unspec extrapyramidal disease	333.90	0—20
	Spinocerebellar degenerative disease	334.x all	0—20
	Anterior horn cell disease	335.x all	0—20
Nervous System	Schilder's disease	341.1	0—64
	Diplegic infantile cerebral palsy	343.0	0—20
	Quadriplegic infantile cerebral palsy	343.2	0—64
	Quadriplegia and Quadriparesis	344.0	0—64
Muscular Dystrophies	Congenital hereditary MD	359.0	0—64
	Hereditary progressive MD	359.1	0—64
	Congenital myotonic dystrophy (Steinert's only)	359.2	0—64
Cerebrovascular	Moyamoya disease	437.5	0—64
Digestive Disease	Short gut syndrome	579.3	0—20
Genitourinary Disease	Chronic glomerulonephritis conditions	582, 582.0, 582.1, 582.2, 582.4, 582.8, 582.81, 582.89, 582.9	0—20 0—20 0—20
	Chronic renal failure diagnosed by a pediatric nephrologist	585	0—20
	Chronic renal failure with dialysis and documented rejection from Medicare	585 V45.1	21—64
Congenital Anomalies	Spina bifida	741.x all	0—64
	Encephalocele, microcephalus, hydrocephalus	742.0, 742.1, 742.3	0—20
	Other Brain Anomalies	742.4	0—20
	Spinal Cord Anomalies	742.5, 742.59	0—64
	Nose: cleft or absent nose only	748.1	0—5
	Web larynx	748.2	0—20
	Only Atresia or agenesis of larynx, trachea, or bronchus	748.3	0—20
	Congenital cystic lung	748.4	0—20
	Agenesis, hypoplasia and dysplasia	748.5	0—20
	Cleft palate	749 except 749.1x	0—20
	Tracheoesophageal fistula	750.3	0—3
	Atresia large intestine	751.2	0—5
	Hirschsprung's, other colon	751.3	0—15
	Biliary atresia, cystic disease of liver	751.61 and 751.62	0—20
	Pancreas	751.7	0—5
	Other digestive (specified)	751.8	0—10
	Urinary system anomalies (only if bilateral)	753.0	0—20
	Cystic kidney disease (only if bilateral)	753.1	0—20
	Polycystic kidney, unspecified type (only if bilateral)	753.12	0—20
	Polycystic kidney, autosomal dominant (only if bilateral)	753.13	0—20
	Polycystic kidney, autosomal recessive (only if bilateral)	753.14	0—20
	Renal dysplasia (only if bilateral)	753.15	0—20
	Medullary cystic kidney (only if bilateral)	753.16	0—20
	Medullary sponge kidney (only if bilateral)	753.17	0—20
	Exstrophy of urinary bladder	753.5	0—20
	Musculoskeletal — skull and face bones	756.0	
	Chondrodystrophy	756.4	0—1
	Osteodystrophy, unspecified	756.50	0—1
	Osteogenesis imperfecta	756.51	0—20
	Osteopetrosis	756.52	0—1
	Osteopoikilosis	756.53	0—1
	Polyostotic fibrous dysplasia of bone	756.54	0—1
	Chondroectodermal dysplasia	756.55	0—1
	Multiple epiphyseal dysplasia	756.56	0—1
	Other osteodystrophies	756.59	0—1
	Anomalies of diaphragm	756.6	0—1
	Anomalies of abdominal wall	756.7	0—1
	Multiple congenital anomalies	759.7	0—10
Other	Ventilator Dependent (non-neonate)	V46.1 and V46.9	1—64

.02 Stop Loss [Case] Management SLM.

A. An MCO enrollee who satisfies the conditions specified in COMAR 10.09.65.22 [who is determined by the Department to be an appropriate candidate for case management] shall be enrolled in Stop Loss [Case] Management (SLM) so long as the enrollee's MCO has given the Department the notice required by COMAR 10.09.65.22B.

B. An SLM participant shall:

(1) (text unchanged)

(2) Receive MCO-covered health care services as specified under a plan of care developed by [an SLM case manager,] the MCO[,] *in cooperation with* the enrollee[,] and the enrollee's family members, caregivers, or guardians, as appropriate; and

(3)[As appropriate to the plan of care, receive those] *Receive case management and appropriate* additional services described by Regulations .06 — .12 of this chapter, and paid by the Program according to the limitations of Regulation .14 of this chapter, subject to the limitations in Regulation .13 of this chapter, *if the Department determines that a Stop Loss Management participant is an appropriate candidate for case management under Stop Loss Management.*

.14 Limitations.

A. (text unchanged)

B. The Department shall pay for a service specified in Regulations .06 — .13 of this chapter or other Program service other than emergency services delivered to a participant only if the service has been [preauthorized] *recommended* by the participant's case manager *and preauthorized by the Department.*

C. In the REM program, the Department may not pay for the following comparable case management services:

(1) HIV targeted case management as described in COMAR 10.09.32, except for HIV Diagnostic Evaluation Services as described in COMAR 10.09.32.03C and .04A;

(2) Healthy Start Case Management as described in COMAR 10.09.38;

(3) Targeted case management for individuals with developmental disabilities as described in COMAR 10.09.48;

(4) Targeted case management for infants and toddlers as described in COMAR 10.09.40; and

(5) Targeted case management for children diverted/returned from out-of-State residential treatment facilities (SRI) as described in COMAR 10.09.49.

10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System

.10 Mental Health Diagnoses and Service Array.

A. — B. (text unchanged)

C. Service Array. Mental health services include:

(1) The following services, which are Medicaid-reimbursable, on a fee-for-service basis:

(a) — (d) (text unchanged)

(e) Psychiatric home health services, under COMAR 10.09.04;

[(e)] *(f)* — [(h)] *(i)* (text unchanged

[(i) Hospital-based psychiatric] *(j) Psychiatric* day treatment services (partial hospitalization), under COMAR 10.21.02;

[(j)] *(k)* Rehabilitation *and other mental health* services, under COMAR 10.09.59, including:

(i) — (iii) (text unchanged)

[(k)] *(l)* (text unchanged)

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

(a) (text unchanged)

(b) [Freestanding psychiatric day treatment services partial hospitalization), under COMAR 10.21.02;

(c)] (text unchanged)

[(d) Supported living services;]

[(e)] *(c)* — [(i)] *(g)* (text unchanged)

D — E. (text unchanged)

10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures

.01 Department's Complaint Process.

The Department shall operate a central complaint [unit] *program* that is designed to:

A. Be accessible to all enrollees through a toll-free telephone hot-line which:

(1)[operates]*Operates* Monday through Friday during extended business hours;

[B. Answer]*(2) Answers* enrollees' questions;

[C.] *(3)* When appropriate, [direct] *directs* recipients to the MCO staff charged with addressing enrollee complaints;

[D.] *(4)* When appropriate, [attempt] *attempts* to resolve issues by contacting the MCO directly; and

[E. Refer] *(5) Refers* issues that can not be resolved [by complaint unit staff] to the complaint [unit] *resolution section* supervisor[, who may:].

B. The complaint resolution supervisor may:

(1) — (2) (text unchanged)

(3) Direct the MCO to provide information necessary for complaint resolution *or to provide a corrective action plan* not later than 5 days from the date of the request; and

(4) Refer disputes to the local ombudsman when the case:

(a) Is too complex for the complaint [unit] *resolution section* to resolve,

(b) — (c) (text unchanged)

.02 Ombudsman Program.

A. The Department shall operate an ombudsman program to:

(1) Investigate disputes between enrollees and MCOs referred by the Department's complaint [unit] *resolution section*;

(2) — (3) (text unchanged)

B. — D. (text unchanged)

E. When a complaint is referred from the Department's complaint [unit] *resolution section*, the local ombudsman may take any or all of the following actions, as appropriate:

(1) — (4) (text unchanged)

F. — J. (text unchanged)

.03 Provider Hotline.

A. (text unchanged)

B. The Department shall, through its provider hotline:

(1) — (3) (text unchanged)

(4) Direct the MCO to provide necessary information for complaint resolution or a corrective action plan not later than 5 days from the date of the request.

C. (text unchanged)

MARTIN P. WASSERMAN, M.D.
Secretary of Health and Mental Hygiene