

MARYLAND REGISTER

Proposed Action on Regulations

Transmittal Sheet PROPOSED OR REPROPOSED Actions on Regulations	Date Filed with AELR Committee	TO BE COMPLETED BY DSD
	10/03/2014	Date Filed with Division of State Documents
		Document Number
		Date of Publication in MD Register

1. Desired date of publication in Maryland Register: 11/14/2014

2. COMAR Codification

Title	Subtitle	Chapter	Regulation
10	09	60	01-.24
10	09	62	01
10	09	63	01-.03, .05 and .06
10	09	64	05-.07 and .10
10	09	65	01,02,04,05,08,10,11,11-1,11-2,12,14,15,19-5,20,21
10	09	66	02, .04, .05 and .07
10	09	67	01, .04, .12 and .26-.28

3. Name of Promulgating Authority

Department of Health and Mental Hygiene

4. Name of Regulations Coordinator **Telephone Number**
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5. Name of Person to Call About this Document

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6. Check applicable items:

New Regulations

Amendments to Existing Regulations

Date when existing text was downloaded from COMAR online: 5/22/14, 6/26/14, 6/30/14, 7/1/14, 7/11/14 .

Repeal of Existing Regulations

Recodification

Incorporation by Reference of Documents Requiring DSD Approval

Reproposal of Substantively Different Text:

: Md. R
(vol.) (issue) (page nos) (date)

Under Maryland Register docket no.: --P.

7. Is there emergency text which is identical to this proposal:

Yes No

8. Incorporation by Reference

Check if applicable: Incorporation by Reference (IBR) approval form(s) attached and 18 copies of documents proposed for incorporation submitted to DSD. (Submit 18 paper copies of IBR document to DSD and one copy to AELR.)

9. Public Body - Open Meeting

OPTIONAL - If promulgating authority is a public body, check to include a sentence in the Notice of Proposed Action that proposed action was considered at an open meeting held pursuant to State Government Article, §10-506(c), Annotated Code of Maryland.

OPTIONAL - If promulgating authority is a public body, check to include a paragraph that final action will be considered at an open meeting.

10. Children's Environmental Health and Protection

Check if the system should send a copy of the proposal to the Children's Environmental Health and Protection Advisory Council.

11. Certificate of Authorized Officer

I certify that the attached document is in compliance with the Administrative Procedure Act. I also certify that the attached text has been approved for legality by David Lapp, Assistant Attorney General, (telephone #410-767-5292) on September 19, 2014. A written copy of the approval is on file at this agency.

Name of Authorized Officer

Joshua M. Sharfstein, M.D.

Title

Secretary

Telephone No.

410-767-6500

Date

October 3, 2014

**Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.60 Primary Adult Care Program Eligibility

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.62 Maryland Medicaid Managed Care Program: Definitions

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.64 Maryland Medicaid Managed Care Program: MCO Application

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.66 Maryland Medicaid Managed Care Program: Access

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.67 Maryland Medicaid Managed Care Program: Benefits

Authority: See attached.

Notice of Proposed Action

□

The Secretary of Health and Mental Hygiene proposes to 1) Repeal in its entirety Regulations .01—.24 under COMAR 10.09.60 Primary Adult Care Program Eligibility; 2) Amend Regulation .01 under COMAR 10.09.62 Maryland Managed Care Program: Definitions;

- 3) Amend Regulations .01, .02, .03, .05, and .06 under COMAR 10.09.63 Maryland Managed Care Program: Eligibility and Enrollment;
- 4) Amend Regulations .05, .06, .07, and .10 under COMAR 10.09.64 Maryland Managed Care Program: MCO Application;
- 5) Amend Regulations .02, .04, .05, .08, .10, .12, .14, .15, .19-5, .20, and .21 and to repeal Regulations .01, .11, .11-1, and .11-2 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations
- 6) Amend Regulations .02, .04, .05, and .07 under COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access; and
- 7) Amend Regulations .01, .04, .12, and .26—.28 and adopt new Regulation .06 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits.

Statement of Purpose

- The purpose of this action is to
- 1) Repeal in its entirety COMAR 10.09.60 Primary Adult Care Eligibility as the program ended January 1, 2014;
 - 2) Remove certain references to substance abuse services and the Specialty Mental Health System as they are being combined and substance abuse is being taken out of the MCO benefit package and covered through the Behavioral health ASO;
 - 3) Add language to allow enrollees to change MCOs if they have been in the same MCO for 12 months;
 - 4) Update medical loss ratio language to clarify that it's calculated separately for the childless adult population.
 - 5) Add language that clarifies that enrollees may be required to use mail order pharmacy for specialty drugs;
 - 6) Require MCOs to provide habilitation services to certain populations as required by the Affordable Care Act;
 - 7) Remove requirement that MCOs provide a plastic identification card;
 - 8) Remove requirement that a paper copy of the provider directory be included as part of the enrollee handbook;
 - 9) Under 10.09.64 MCO application, add disease management as a requirement; and
 - 10) Remove obsolete language and update incorrect references.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

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

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499; TTY:800-735-2258, or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through December 15, 2014. A public hearing has not been scheduled.

Economic Impact Statement Part C

- A. Fiscal Year in which regulations will become effective: FY 2015
- B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?
- C. If 'yes', state whether general, special (exact name), or federal funds will be used:
- D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:
- E. If these regulations have no economic impact under Part A, indicate reason briefly:
Changes are to clarify policy and remove obsolete language.
- F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.
These regulations affect MCOs which are not small businesses.
- G. Small Business Worksheet:

Attached Document:

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAM

10.09.62 Maryland Medicaid Managed Care Program: Definitions

10.09.62.01 (5/22/14)

.01 Definitions.

A. Except as expressly limited, in COMAR 10.09.62—10.09.75 the following terms have the meanings indicated.

B. Terms Defined.

(1) (text unchanged)

[(1-1)] (2)—[(2-2)] (5) (text unchanged)

[(3) "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.

(4) "Addictions specialist" means a specialist on-site in a local department of social services to perform duties required by the Welfare Innovation Act of 2000 which includes:

(a) Screening adult and minor parent recipients of Temporary Cash Assistance (TCA) for substance abuse; and

(b) Referring them for further assessment or treatment, or both.]

[(5)] (6) (text unchanged)

[(6)] (7) Administrative Services Organization.

(a) "Administrative services organization (ASO)" means an organization with which [MHA and the CSAs contract] *the Department contracts* to assist in the management of [the specialty mental health system] *behavioral health services*.

(b) (text unchanged)

[(7) "Adult or minor parent TCA recipient" means an individual who receives Temporary Cash Assistance under the Family Investment Program, and is:

(a) 18 years old or older; or

(b) Younger than 18 years old and a parent.]

(8) "Advanced practice nurse" means a nurse practitioner, nurse midwife, nurse anesthetist, or nurse psychotherapist who is licensed and certified under Health Occupations Article, Title 8, Annotated Code of Maryland, and COMAR [10.27.] *10.27.01*

(9)—(21) (text unchanged)

(22) [Case Management.]

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

[(b) "Case management" means, in the context of COMAR 10.09.70, a service provided to coordinate, link, plan, and monitor mental health and related support services to an individual.]

(23)—(41) (text unchanged)

[(42) "Drug abuse" has the meaning stated in Health-General Article, §8-101(k), Annotated Code of Maryland.]

[(43)] (42)—[(90)] (89) (text unchanged)

[(91) "Intermediate care facility-alcoholic (ICF-A)" means an institution that:

(a) Falls within the scope of Health-General Article, §19-308, Annotated Code of Maryland;

(b) Is certified as required under COMAR 10.47.01 by the Alcohol and Drug Abuse Administration and the Office of Health Care Quality, or other applicable standards established by the jurisdiction in which the service is provided; and

(c) Provides residential substance abuse treatment services.]

[(92)] (90)—[(96)] (94) (text unchanged)

[(97) "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.]

[(98)] (95)—[(111)] (108) (text unchanged)

[(112) "Mental health emergency" means, in the context of COMAR 10.09.70, that an individual presents a danger to the life or safety of the individual or others.

(113) "Mental health professional" means an individual who is licensed, certified, or otherwise legally authorized by Health Occupations Article, Annotated Code of Maryland, to provide the service for which the individual is privileged.

(114) "Mental health case management" means case management services approved for Medicaid reimbursement under COMAR 10.09.45.

(115) "MHA medical director" means, in the context of COMAR 10.09.70, the psychiatrist appointed by the Director of the Mental Hygiene Administration (MHA) to oversee the clinical quality of services in the specialty mental health services (SMHS) system.]

[(116)] (109)—[(118)] (111) (text unchanged)

[(119)] "Mobile crisis" means, in the context of COMAR 10.09.70, mental health treatment and support services that are provided at an appropriate site in the community to an individual who is experiencing or at risk to experience a psychiatric crisis.

(120) "Mobile treatment services (MTS)" means, in the context of COMAR 10.09.70, services provided by a program approved under COMAR 10.21.19.]

[(121)] (112) (text unchanged)

[(122)] "Natural support" means, in the context of COMAR 10.09.70, an individual's family members, significant others, friends, neighbors, colleagues, and community resources.]

[(122-1)] (113)—[(128)] (120) (text unchanged)

[(129)] "Outpatient addictions therapy" means, in the context of COMAR 10.09.69, services for the treatment of drug or alcohol abuse.

(130) "Outpatient mental health clinic (OMHC)" means, in the context of COMAR 10.09.70, a program approved under COMAR 10.21.20.]

[(131)] (121)—[(132)] (122) (text unchanged)

[(133)] "Partial hospitalization" means, in the context of COMAR 10.09.70, psychiatric day treatment as approved under COMAR 10.21.02.]

[(134)] (123) (text unchanged)

[(135)] "Peer support" means, in the context of COMAR 10.09.70, activities that individuals who are receiving or who have received mental health services provide to each other to promote understanding and full participation in community life.]

[(136)] (124) (text unchanged)

[(137)] "Placement appraisal" means the process by which a qualified provider determines, based on the 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.]

[(138)] (125)—[(142)] (131) (text unchanged)

[(143)] Repealed.]

[(144)] (132)—[(146)] (134) (text unchanged)

[(147)] Repealed.]

[(148)] (135)—[(149)] (136) (text unchanged)

[(150)] "Privileging" means, in the context of COMAR 10.09.70, the process by which a program determines that staff members are qualified to perform assigned duties.

(151) "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.]

[(152)] (137)—[(155)] (140) (text unchanged)

[(156)] "Psychiatric day treatment" means, in the context of COMAR 10.09.70, a program approved under COMAR 10.21.02.

(157) "Psychiatric rehabilitation program (PRP)" means, in the context of COMAR 10.09.70, a program approved under COMAR 10.21.21.

(158) "Psychiatrist" means a physician who is certified by the American Board of Psychiatry and Neurology or who has completed the minimum educational and training requirements to be qualified to take the Board examination.]

[(159)] (141)—[(160)] (142) (text unchanged)

[(161)] "Quality management (QM)" means, in the context of COMAR 10.09.70, the process to maintain and improve the quality of services.]

[(162)] (143)—[(168)] (149) (text unchanged)

[(169)] "Residential crisis services" means, in the context of COMAR 10.09.70, mental health treatment and support services provided to individuals in a community-based residential setting to assist the individual to avoid inpatient admission.

(170) "Residential drug-free treatment program" (sometimes referred to as "therapeutic community" in the drug treatment field) means a live-in center, certified by the Licensing and Certification Administration and the Alcohol and Drug Abuse Administration of the Department, that operates 24 hours per day, 7 days a week, staffed by professional and paraprofessional persons, offering nonchemotherapeutic treatment and rehabilitation services for one or more drug abusers.

(171) "Residential rehabilitation program (RRP)" means, in the context of COMAR 10.09.70, a program that is approved under COMAR 10.21.22.

(172) "Residential service agency" means, in the context of COMAR 10.09.69, an agency licensed by the Department in accordance with COMAR 10.07.05.

(173) "Respite care" means, in the context of COMAR 10.09.70, a service provided on a short-term basis in a community-based setting to assist an individual's home caregiver to maintain the individual in the home by temporarily freeing the caregiver from the responsibility of supervision.]

[(174)] (150)—[(176)] (152) (text unchanged)

[(177)] "Serious and persistent mental disorder" means, in the context of COMAR 10.09.70, a disorder that is:

(a) Manifested in an individual 18 years old or older;

(b) Diagnosed, according to the current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary as:

(i) Schizophrenic disorder,

(ii) Major affective disorder,

(iii) Other psychotic disorder, or

(iv) Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and

(c) Characterized by impaired role functioning, on a continuing or intermittent basis, for at least 2 years, including at least three of the following:

(i) Inability to maintain independent employment,

(ii) Social behavior that results in intervention by the mental health system,

(iii) Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,

(iv) Severe inability to establish or maintain a personal social support system,

(v) Need for assistance with basic living skills.

(178) "Serious emotional disturbance" means, in the context of COMAR 10.09.70, a condition that is:

(a) Manifested in an individual younger than 18 years old, or, if the individual is eligible for EPSDT services, younger than 21 years old;

(b) Diagnosed according to the current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary; and

(c) Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.]

[(179)] (153)—[(179-1)] (154) (text unchanged)

[(180)] (155) "Somatic care" means medical care that addresses an individual's physical health care needs [, including substance abuse treatment].

[(181)] (156) "Special needs population" means a group of recipients who share a special health care need [and which is] as specified in COMAR [10.09.65.04—.11] 10.09.65.04.

[(182)] (157)—(184)] (159) (text unchanged)

[(185)] (160) "Specialty [mental] behavioral health services" means any [mental] behavioral health services other than primary [mental] behavioral health services.

[(186)] (161)—[(188)] (164) (text unchanged)

[(189)] "Substance abuse" means alcohol abuse or drug abuse.]

[(190)] (165)—[(191)] (166) (text unchanged)

[(192)] "Supported employment" means, in the context of COMAR 10.09.70, activities to enable an individual to obtain and maintain regular employment.

(193) "Supported living" means, in the context of COMAR 10.09.70, activities to enable an individual to maintain housing of the individual's choice.]

[(194)] (167)—[(197)] (170) (text unchanged)

[(198)] "Therapeutic nursery program (TNP)" means, in the context of COMAR 10.09.70, a program approved under COMAR 10.21.18.]

[(199)] (171) (text unchanged)

[(200)] "Urgent mental health care" means, in the context of COMAR 10.09.70, services for an individual with a mental disorder that manifests itself by symptoms of sufficient severity that the absence of prompt mental health treatment could reasonably be expected to result in a mental health emergency.]

[(201)] (172)—[(202)] (173) (text unchanged)

10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment

Authority: Health-General Article, §§15-103(b)(3) (4) and (6), (16) and (23), Annotated Code of Maryland

10.09.63.01 (6/26/14)

.01 Eligibility.

A. (text unchanged)

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

(1) Has been, or is expected to be, continuously institutionalized for more than 30 successive days in:

- (a) (text unchanged)
 - (b) An [IMD] *institution for mental disease (IMD)*;
- (2)—(7) (text unchanged)

10.09.63.02 (6/26/14)

.02 Enrollment.

A. The Department shall provide to waiver-eligible individuals:

(1) Materials regarding each MCO providing services in the eligible individual's county of residence including, but not limited to[, for each MCO]:

- (a) (text unchanged)
- (b) A schedule of the benefits offered, including any benefits offered beyond the basic required package described in *COMAR 10.09.67*; and

(c) If applicable, a list of services that the MCO does not provide, reimburse for, or provide coverage of, because of moral or religious objections[; and

(d) A narrative description of the clinical expertise and experience of the MCO's network for special needs populations;].

- (2)—(3) (text unchanged)

B.—L. (text unchanged)

10.09.63.03 (6/26/14)

.03 Health Service Needs Information.

A. The Department *or its agent* shall:

(1) Attempt to complete the health service needs information at the time of enrollment[;or

(2) If the health service needs information is not completed at the time of enrollment complete it within 5 days, unless the recipient cannot be reached or is uncooperative].

B.—C. (text unchanged)

[D. If the Department cannot reach the recipient or the recipient is uncooperative, the Department shall notify the MCO of its failure to complete the health service needs information, and remove all obligations on the MCO to provide expedited service pursuant to the health service needs information for the recipient.]

[E.] D. The Department shall inform a recipient identified in connection with the health service needs information as having a [mental] *behavioral* health problem that the individual may self-refer to the [specialty mental health system pursuant to] *behavioral health ASO for services as described in COMAR [10.09.70.] 10.09.59 and 10.09.80.*

10.09.63.05 (7/28/14)

.05 Reassignment.

A. [Annually, upon the anniversary date of initial enrollment in an MCO] *Once every 12 months*, a Program recipient may elect to:

- (1)—(2) (text unchanged)

(3) Enroll in an MCO outside the recipient's local access area, upon the approval of the Department and the MCO [located outside the recipient's local access area].

B. [Sixty days before an enrollee's anniversary date of enrollment, the] *The* Department shall notify the enrollee [of the annual right to change the enrollee's MCO] *no less than 60 days before the start of each new enrollment period.*

[C. If the enrollee fails to respond timely to the Department's notice of opportunity to change MCOs, the Department shall reassign the enrollee in the same MCO in which the enrollee is currently enrolled.]

[D.] C.—[F.] E. (text unchanged)

10.09.63.06 (6/26/14)

.06 Disenrollment.

A.—E. (text unchanged)

F. Effective Date of Disenrollment.

- (1) (text unchanged)

(2) An enrollee's disenrollment shall take effect:

(a) Immediately when the enrollee dies;

(b) From the first day of the month the Department receives notice [through the CARES system of] *that the enrollee* lost Medicaid eligibility;

(c)—(d) (text unchanged)

(3) When an enrollee becomes eligible for Medicare, the enrollee's disenrollment from the MCO is effective on the:

(a) (text unchanged)

(b) Last day of the month *before the month* in which the enrollee turns 65 years old.

- (4)—(6) (text unchanged)

G. An MCO shall make a good faith effort to give written notice to the Department when enrollees *have the right to change MCOs under §A(1)(e) of this regulation [within 15] 30 days [after receipt or issuance of the PCP's termination notice] before the effective date of the termination.*

(1) *In addition to the notification required in §G of this regulation, the MCO shall provide the Department with a list of the affected enrollees in a format specified by the Department; and*

(2) *If applicable, the termination survey required under COMAR 10.09.17B(4).*

H. (text unchanged)

10.09.64 Maryland Medicaid Managed Care Program: MCO Application

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

10.09.64.05 (6/30/14)

.05 Access and Capacity.

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

A. A map or maps showing the county or counties in which the applicant proposes to provide health care services, and the service area boundaries. [For applications received after June 30, 2010, the service area shall include at least two of the following regions:

(1) Allegany, Garrett, Washington;

(2) Prince George's Northeast, Prince George's Northwest, Prince George's Southeast, Prince George's Southwest;

(3) Calvert, Charles, St. Mary's;

(4) Caroline, Kent, Queen Anne's, Talbot, Cecil; or

(5) Dorchester, Somerset, Wicomico, Worcester.]

B. [Effective January 1, 2015, the] *The* service area shall include at least two underserved counties as defined in §C of this regulation.

C.—J. (text unchanged)

K. Documentation that enrollees will have access to primary care services, including *pharmacy*, obstetrics/gynecology and diagnostic laboratory services, within a reasonable distance of their places of residence, demonstrated by showing the availability of these services in:

(1) Urban areas, [within 30 minutes travel time or] within a 10-mile radius; [and]

(2) Rural areas, [within 30 minutes travel time or] within a 30-mile radius; *and*

(3) *Suburban areas, within a 20 mile radius.*

[L. Documentation that enrollees will have access to pharmacy services within a reasonable distance of their places of residence, demonstrated by showing the availability of these services in:

(1) Urban areas, within 10 minutes travel time or within a 5-mile radius; and

(2) Rural areas, within 30 minutes travel time or within a 30-mile radius;]

[M.] *L.* Documentation of any reasons for which they are unable to meet the access requirements of [§§K and L] §K of this regulation;

[N.] *M.*—[O.] *N.* (text unchanged)

10.09.64.06 (6/30/14)

.06 Access and Capacity: Benefits and Appointments.

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

A.—F. (text unchanged)

G. Documentation of the [following:

(1) The] applicant's preparedness to work with the Department's [specialty mental health system] *behavioral health ASO* for coordination of somatic care, [including substance abuse treatment, mental health] *behavioral health* care, and all appropriate drug utilization review[; and

(2) The clinical experience and expertise of the applicant's provider network in providing somatic care for enrollees with severe and persistent mental illness;].

H.—P. (text unchanged)

10.09.64.07 (6/30/14)

.07 Access and Capacity: Contracts and Provider Applications.

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

A.—D. (text unchanged)

E. Written evidence of the applicant's organizational capacity to provide special programs adequate to meet the individual needs of all enrollees, including:

(1)—(3) (text unchanged)

(4) [Substance abuse services] *Disease management*;

(5) (text unchanged)

(6) All Medicaid-covered services required to comply with State statutes and regulations mandating health and [mental] behavioral health services for children in State-supervised care;

F.—G. (text unchanged)

10.09.64.10 (6/30/14)

.10 Special Needs Populations.

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

A.—B. (text unchanged)

C. Written evidence, including treatment protocols, of the applicant's ability to provide the range of clinical and support services specified in COMAR [10.09.65.05-----11] 10.09.65.05—.10 and .13, to ensure appropriate and coordinated services to the following special populations:

(1)—(6) (text unchanged)

[(7) Individuals in need of substance abuse treatment; and]

D. Referral protocols that demonstrate the conditions under which PCPs will make the arrangements for children with special health care needs to be referred to MCO specialty care networks and when appropriate the behavioral health ASO for services as described in COMAR 10.09.59 or 10.09.80.

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Insurance Article, §15-112, 15-605, and 15-1008; Health-General Article, §2-104, 15-102.3, and 15-103; Annotated Code of Maryland

10.09.65.02 (7/1/14)

.02 Conditions for Participation.

A.—D. (text unchanged)

E. Assurance Against Insolvency.

(1)—(4) (text unchanged)

(5) If, in accordance with [§F (4)] §E(4) of this regulation, the Department designates funds sufficient to increase the applicant's initial surplus to \$1,250,000, the Department shall designate \$250,000 in trust for the applicant.

(6) Funds designated by the Secretary pursuant to [§F(3)—(5)] §E(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 Insurance Article, §5-605, Annotated Code of Maryland.

(7)—(9) (text unchanged)

F. 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)—(d) (text unchanged)

(4)—(5) (text unchanged)

G.—M. (text unchanged)

N. The requirements of Regulation .17A(2) of this chapter, or [§N(1)] §M(1) of this regulation, may not be construed to:

(1)—(3) (text unchanged)

O.—Q. (text unchanged)

R. The chief executive officer of an MCO or his or her designee shall certify, under penalty of perjury, that any books, records, files, accounts, or other documents requested under [§§Q and R] §§P and Q of this regulation are current, accurate, and complete to the best of that individual's knowledge.

S.—T. (text unchanged)

U. Disclosure of Provider Incentive Plans.

(1) (text unchanged)

(2) An MCO shall include in the disclosures required by [§V(1)] §U(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.

V.—Z. (text unchanged)

AA. Federal financial participation is not available for amounts expended for excluded providers in [§N(2)] §M(2) of this regulation[, except for emergency services].

BB. For complaints of provider fraud and abuse that warrant a preliminary investigation, the MCO's report required in [§T] §S of this regulation shall include:

(1)—(8) (text unchanged)

CC.—DD. (text unchanged)

EE. [An MCO participating in the Program shall meet the following standards] *The following applies to the Department's Health Home Program as described in COMAR 10.09.33:*

(1)—(6) (text unchanged)

10.09.65.04 (7/9/14)

.04 Special Needs Populations.

A. (text unchanged)

B. Special needs populations consist of the following non-mutually exclusive populations:

(1)—(5) (text unchanged)

(6) Individuals with HIV/AIDS; *and*

[(7) Individuals with a need for substance abuse treatment; and]

[(8)] (7) (text unchanged).

C (text unchanged)

10.09.65.05 (7/9/14)

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

A.—F. (text unchanged)

G. An MCO shall ensure coordination with the Department's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) [nurse review monitoring] program.

H.—K. (text unchanged)

10.09.65.08 (7/9/14)

.08 Special Needs Populations — Pregnant and Postpartum Women.

A.—B. (text unchanged)

C. An MCO shall *ensure that prenatal providers:*

(1)—(2) (text unchanged)

D. (text unchanged)

E. An MCO shall [provide a comprehensive substance abuse treatment program for] *refer* pregnant and postpartum women with a substance [abusers, which includes:

(1) Access to substance abuse treatment within 24 hours of the enrollee's request;

(2) A triage screening process to determine the appropriate level of care;

(3) Case management services available for substance-abusing pregnant and postpartum women; and

(4) A network of providers, including intensive outpatient programs, capable of addressing the comprehensive service needs of substance-abusing pregnant and postpartum women, including specialized day treatment that allows for children to accompany their mothers.] *use disorder to the behavioral health ASO for substance use treatment within 24 hours of request.*

F.—K. (text unchanged)

10.09.65.10 (7/9/14)

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

A.—D. (text unchanged)

E. An individual with HIV/AIDS who [is] *has* a substance [abuser] *use disorder* shall [receive] *be referred to the behavioral health ASO for substance abuse treatment within 24 hours of request.*

[F.] E. (text unchanged)

10.09.65.12 (7/9/14)

.12 Consumer Advisory Board.

A. (text unchanged)

B. The consumer advisory board membership shall:

(1) (text unchanged)

(2) Be comprised of no less than one third representation from the MCO's special needs populations, or their representatives *and the MCO's special needs coordinator.*

C.—D. (text unchanged)

10.09.65.14 (7/9/14)

.14 Referral to [Specialty Mental Health Delivery System] Behavioral Health ASO.

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

B. An enrollee may self-refer to the [Specialty Mental Health Delivery System as specified] *behavioral health ASO for services described* in COMAR [10.09.70.] 10.09.59 or 10.09.80.

C. If an enrollee's primary care physician determines that primary [mental] *behavioral* health services are not sufficient to meet the enrollee's [mental health] needs, the primary care physician shall refer the enrollee to the [Specialty Mental Health Delivery System as specified] *behavioral health ASO for services described* in COMAR [10.09.70.] 10.09.59 or 10.09.80.

D. If an MCO determines that primary [mental] *behavioral* health services are not sufficient to meet the enrollee's [mental health] needs, the MCO shall refer the enrollee to the [Specialty Mental Health Delivery System as specified] *behavioral health ASO for services described* in COMAR [10.09.70.] 10.09.59 or 10.09.80.

E. An MCO shall cooperate with the [Specialty Mental Health Delivery System] *behavioral health ASO* in developing referral procedures and protocols.

10.09.65.15 (7/10/14)

.15 Data Collection and Reporting.

A. (text unchanged)

B. Encounter Data.

(1) An MCO shall submit encounter data [monthly,] reflecting 100 percent of provider-enrollee encounters, in CMS1500 and UB04 format or an alternative format previously approved by the Department.

(2)—(3) (text unchanged)

C. Monthly Reports.

[(1) An MCO shall submit to the Department monthly a report detailing which primary care provider panels are accepting new patients to new enrollees.]

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

[(3) Within 10 calendar days after the close of each calendar month, an MCO shall submit a list of all preservice denials or reduction of services or benefits issued by the MCO or MCO subcontractors during the preceding month, which shall include for each recipient:

(a) Name;

(b) Medical assistance number;

(c) Date of denial or reduction of services;

(d) Service or benefit denied or reduced;

(e) Reason for denial or reduction of services;

(f) Date of denial or reduction of services letter; and

(g) An indication of review by the MCO Medical Director.]

[(4)] (2) (text unchanged)

D. Quarterly Reports. An MCO shall submit to the Department:

(1) Within 30 calendar days of the close of each calendar quarter, quality assurance reports including, but not limited to:

(a)—(b) (text unchanged)

(2) *Within 10 calendar days after the close of each calendar quarter, in the format specified by the Department, a list of all pre-service denials or reduction of services or benefits issued by the MCO or MCO subcontractors during the preceding quarter.*

[(2)] (3) (text unchanged)

(4) *On a quarterly basis and in a format specified by the Department, amounts the MCO has cost-avoided and recovered and the number of cases the MCO has handled in each case area during the quarter.*

E.—J. (text unchanged)

[K. Reporting to Local Departments of Social Services. An MCO shall provide, or ensure that its providers provide, the notice required by Regulations .11-1 and .11-2 of this chapter.]

[L.] K. (text unchanged)

10.09.65.19-5 (7/30/14)

.19-5 MCO Loss Ratio.

A.—E. (text unchanged)

F. Annual Loss Ratio Calculation.

(1)—(2) (text unchanged)

(3) *Effective for services incurred after January 1, 2014, the Department shall calculate the MCO's annual loss ratio as described in §F(1) and (2) of this regulation separately for the childless adult population.*

G. (text unchanged)

H. Adjustment Amount.

(1) [Starting with the implementation of the January 2010 capitation rates, the] *The Secretary*, in consultation with the Commissioner, may adjust an MCO's capitation payments [in the amounts specified in §H of this regulation:

(a) For the first year in which an adjustment is made pursuant to this capitation, the adjustment may not exceed 50 percent of the difference between the capitation amount:

(i) Actually paid by the Department to the MCO during the service year; and

(ii) That, if paid by the Department during the service year instead of the actual payment amount, would have resulted in the MCO having a loss ratio of 85 percent for the service year; and

(b) For the second consecutive year in which an adjustment is made pursuant to this regulation, the adjustment may not exceed 75 percent of the difference between the capitation amount:

(i) Actually paid by the Department to the MCO during the service year; and

(ii) That, if paid by the Department during the service year instead of the actual payment amount, would have resulted in the MCO having a loss ratio of 85 percent for the service year; and

(c) For the third consecutive year in which an adjustment is made pursuant to this regulation and thereafter,] *and* the adjustment may not exceed 100 percent of the difference between the capitation amount:

(i)—(ii) (text unchanged)

(2) (text unchanged)

I. (text unchanged)

10.09.65.20 (9/18/14)

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

A. MCO Payment for Self-Referred Services.

(1)—(9) (text unchanged)

[(10) An MCO shall reimburse out-of-plan providers at the Medicaid fee-for-service rate for the substance abuse services described in COMAR 10.09.67.28.]

[(11)] (10) (text unchanged)

B.—D. (text unchanged)

10.09.65.21 (7/10/14)

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

A. [For any FQHC that has agreed to] *FQHC's shall* be reimbursed under the Alternative Payment System (APS) [for dates of service on or after January 1, 2005:].

(1) (text unchanged)

(2) [The MCO] *MCOs* shall reimburse any contracted FQHC, the FQHC's rate established in accordance with COMAR 10.09.08.05-1A.

[B. For any FQHC choosing not to participate in the APS for dates of service on or after January 1, 2005, the MCO shall reimburse the contracted FQHC as follows:

(1) At least the current calendar year's medical FQHC market rate per visit for Medicaid covered services other than dental services;

(2) MCOs and FQHCs shall certify annually to the Department that reimbursement to each FQHC for that year meets the requirements specified in §§A and B of this regulation;

(3) The Department shall reimburse each FQHC on a monthly basis a supplemental payment equaling the difference between the rate specified in §B(1) and (2) of this regulation and each FQHC's corresponding per visit rate established in accordance with COMAR 10.09.08.05-1A for Medicaid-covered FQHC services;

(4) The amount of supplemental payment by the Department to each FQHC will be calculated on the number of visits occurring on or after January 1, 2001, submitted by MCOs in monthly encounter data.]

[C.] *B.* For self-referred services described in Regulation .20 of this chapter, the MCO shall pay the FQHC's usual rate in accordance with [§§A and B] §A of this regulation, regardless of the FQHC's contracted status with the MCO.

10.09.66 Maryland Medicaid Managed Care Program: Access

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

10.09.66.02 (7/11/14)

.02 Access Standards: Enrollee Handbook and Provider Directory.

A. (text unchanged)

B. An MCO shall, at the time of enrollment, and anytime upon request, furnish each enrollee with a copy of the MCO's enrollee handbook that includes the following current information:

(1) (text unchanged)

(2) Information on how to access urgent care and emergency care services *and the fact that prior authorization is not required for these services.*

(3) (text unchanged)

(4) The availability of [specialty mental] *behavioral* health services that are not included in the MCO's benefits package, and how to access these services;

(5)—(6) (text unchanged)

[(7) Information about the MCO, including its primary care service locations;

(8) A listing of the MCO's hospital providers, of both inpatient and outpatient services, in the enrollee's county, their addresses, and services provided;

(9) A listing of the MCO's pharmacy providers in the enrollee's county and their addresses;

(10) A listing of the individual practitioners who are the MCO's primary and specialty care providers in the enrollee's county, grouped by medical specialty, giving:

(a) Name;

(b) Address;

(c) Practice location or locations;

(d) An indication whether or not the provider is accepting new Medicaid patients; and

(e) An indication whether or not access to the provider is otherwise limited, for example by age of patient or number of enrollees the provider will serve;]

[(11)] (7)—[(15)] (11) (text unchanged)

[(16) The fact that prior authorization is not required for emergency service;]

[(17)] (12)—[(19)] (14) (text unchanged)

[(20)] (15) Advanced directives as set forth in 42 CFR §438.6(i)(2), as amended;[and]

[(21)] (16) Additional information that is available upon request, including the following:

(a) (text unchanged)

(b) Physician incentive plans; and

(17) *Information on how to access or obtain the MCO's provider directory.*

C. *Provider Directory*

(1) *An MCO shall provide enrollees with information regarding their provider networks including:*

(a) *Its primary care service locations;*

(b) *A listing of the MCO's hospital providers, of both inpatient and outpatient services, in the enrollee's county, their addresses, and services provided;*

(c) *A listing of the MCO's pharmacy providers in the enrollee's county and their addresses; and*

(d) *A listing of the individual practitioners who are the MCO's primary and specialty care providers in the enrollee's county, grouped by medical specialty, giving:*

(i) *Name;*

(ii) *Address;*

(iii) *Practice location or locations;*

(iv) *An indication of whether or not the provider is accepting new patients; and*

(v) *An indication of whether or not access to the provider is otherwise limited, for example by age of patient or number of enrollees the provider will serve.*

(2) *Upon request by an enrollee, an MCO shall furnish a paper copy of the provider directory.*

[C.] D. An MCO shall notify all enrollees of their right to request and obtain the information listed in [§B] §§B and C of this regulation at least once a year.

E. *An MCO shall make a good faith effort to keep the Department's online provider directory accurate by submitting regular updates when its provider's network status changes.*

10.09.66.04 (7/14/14)

.04 Access Standards: Information for Providers.

A. An MCO shall develop and make available either electronically or by hard copy to all of its PCP and specialty care providers a Medicaid requirements manual, including periodic updates as appropriate, and shall:

(1)—(2) (text unchanged)

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

(a)—(c) (text unchanged)

[(d) Substance abuse screening treatment and referral services, including an explanation of the notification requirements applicable to enrollees who are adult or minor parent TCA recipients, and the MCO's procedures for facilitating the required notice;]

[(e)] (d)—[(h)] (g) (text unchanged)

[(i)] (h) Detection of mental health problems or substance use disorder during routine or follow-up screening, to be treated either through the MCO or referred [for specialty mental] to the behavioral health ASO for services; and

(4) (text unchanged)

B.—C. (text unchanged)

10.09.66.05 (7/11/14)

.05 Access Standards: PCPs and MCO's Provider Network.

- A. Primary Care Provider (PCP).
- (1)—(3) (text unchanged)
 - (4) If the enrollee's parent, guardian, or caretaker, as appropriate, chooses a non-EPSDT certified PCP in accordance to §A(3) of this regulation, within 30 days of enrollment, the MCO shall:
 - (a) (text unchanged)
 - (b) Include in the notification [, with a copy to the Department,] an explanation of the:
 - (i)—(iii) (text unchanged)
 - (5)—(7) (text unchanged)
- B. (text unchanged)

10.09.66.07 (7/11/14)

.07 Access Standards: Clinical and Pharmacy Access.

- A. Appointments.
- (1) New Enrollees: Initial Appointment.
 - (a) (text unchanged)
 - (b) Unless the new enrollee is assigned to a PCP who was the enrollee's established provider of care immediately before the enrollee's enrollment, and, consistent with any applicable periodicity schedule, the PCP concludes that no immediate initial appointment is necessary:
 - (i)—(iii) (text unchanged)
 - (iv) If the new enrollee is identified to be at high risk by the health [risk assessment] *service needs information form*, the MCO shall ensure that an initial appointment is scheduled to occur within 15 business days of the MCO's receipt of the enrollee's completed health risk assessment.
 - (2)—(3) (text unchanged)
- B.—E. (text unchanged)

10.09.67 Maryland Medicaid Managed Care Program: Benefits

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

10.09.67.01 (7/11/14)

.01 Required Benefits Package — In General.

- A. Except for non-covered services set forth in Regulation .27 of this chapter *and the non-capitated services described in COMAR 10.09.70*, an MCO shall provide its enrollees with a benefits package that includes the covered services specified in this chapter when these services are deemed to be medically necessary.
- B. (text unchanged)
- C. [Except for specialty mental health services, any] *Any* limitations set forth in [Regulation .27 of] this chapter on covered services are not applicable to services required by enrollees who are younger than 21 years old when it is shown that the services are medically necessary to correct or lessen health problems detected or suspected by EPSDT screening services, as described in Regulation .20 of this chapter.
- D. Cost Sharing and Prohibitions.
- (1) (text unchanged)
 - (2) An MCO may not:
 - (a) (text unchanged)
 - (b) Restrict its enrollees' access to needed drugs and related pharmaceutical products by requiring that enrollees use mail-order pharmacy providers;] or
 - [(c)] (b) (text unchanged)
- E.—F. (text unchanged)

10.09.67.04 (7/14/14)

.04 Benefits — Pharmacy Services.

- A. An MCO shall provide to its enrollees all medically necessary pharmaceutical services and pharmaceutical counseling, including but not limited to:
- (1)—(11) (text unchanged)
 - (12) Nonlegend ergocalciferol liquid (Vitamin D); *and*
 - (13) Emergency contraceptives for female recipients[; and
 - (14) All dosage forms of tobacco cessation products including, but not limited to, patches, chewing gum, lozenges, inhalers and nasal sprays].
- B. Except as provided in [§C] §D of this regulation, an MCO is required to provide only those drugs and related pharmaceutical products that are prescribed or ordered by:
- (1)—(2) (text unchanged)

(3) [An SMHS] A *behavioral health* provider for drugs not in the [SMHS] *behavioral health* formulary.

C. (text unchanged)

D. Drug Formulary.

(1)—(3) (text unchanged)

(4) Effective July 1, 2009, an MCO shall include in its formulary the following drugs:

(a)—(c) (text unchanged)

[(d) Naltrexone;]

[(e)] (d) Medroxyprogesterone; and

[(f)] (e) Liothyronine; and].

[(g) Disulfiram.]

(5) (text unchanged)

(6) Unless approved by the Department, an MCO may not require or utilize prior authorization or step therapy criteria for coverage of formulary drugs if such prior authorization or step therapy requires a recipient to use a drug that is included in the [SMHS] *behavioral health* formulary [as described in COMAR 10.09.70.02E].

E. Any option for accessing pharmacy services by mail order may be implemented only at the request of the enrollee *except for when the drug is a specialty drug as defined in §F of this regulation.*

F. *In this regulation, the term “specialty drug” means:*

(1) *A prescription drug that:*

(a) *Is prescribed for an individual with a complex, chronic or rare medical condition;*

(b) *Costs \$600 or more for up to a 30-day supply;*

(c) *Is not typically stocked at retail pharmacies; and*

(d) *Requires a difficult or unusual process of delivery to the patient in the preparation, handling storage, inventory or distribution of the drug; or*

(2) *Requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.*

G. *If an enrollee subsequently requests to use a retail pharmacy for specialty drugs the MCO may not limit the enrollee to the use of a mail order pharmacy.*

[F.] H—[H.] J. (text unchanged)

10.09.67.06 (7/14/14)

.06 [Repealed.] Benefits — Habilitation Services for Medicaid Expansion Populations

A. *An MCO shall provide the following medically necessary habilitation services to enrollees eligible for Medical Assistance under §1902 (a)(10)(A)(i)(VIII) of the Social Security Act:*

(1) *Physical therapy;*

(2) *Occupation therapy; and*

(3) *Speech therapy.*

B. *At a minimum, an MCO shall provide the services in hospital inpatient and outpatient departments and physical therapy in an outpatient community setting.*

10.09.67.12 (7/15/14)

.12 Benefits — Long-Term Care Facility Services.

A. An MCO shall provide to its enrollees medically necessary services in a chronic hospital, a chronic rehabilitation hospital, or a nursing facility for:

(1) (text unchanged)

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

B.—C. (text unchanged)

D. The Department’s determination as described in [D] §C of this regulation is only applicable if the enrollee is still in the long-term care facility on the 31st day.

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

F.—G. (text unchanged)

10.09.67.26 (7/14/14)

.26 Benefits — Primary Mental Health Services.

An MCO shall provide to its enrollees medically necessary primary mental health services, including appropriate referrals *for service* to the Department’s [specialty mental health delivery system] *behavioral health ASO* as described in COMAR [10.09.70.] 10.09.59

10.09.67.27 (7/14/14)

.27 Benefits — Limitations.

A. (text unchanged)

B. An MCO is not required to provide any of the [following] benefits or services which are reimbursed directly by the Department [:

- (1) Specialty mental health services, including IMD services;
- (2) Long-term care services except for those outlined in COMAR 10.09.67.07B and COMAR 10.09.67.12A;
- (3) Viral load testing used in treatment of HIV/AIDS;
- (4) Audiology services including the purchase, examination, or fitting of hearing aids and supplies, and tinnitus masker for enrollees younger than 21 years old;
- (5) The remaining days of a hospital admission following enrollment in the MCO if the recipient was admitted to the hospital before the date of the recipient's enrollment;
- (6) An abortion pursuant to COMAR 10.09.02.04G, except when a woman has been determined eligible for Medical Assistance benefits under COMAR 10.09.11;
- (7) Physical therapy, speech therapy, occupational therapy, and audiology services when:
 - (a) The enrollee is younger than 21 years old; and
 - (b) The services are not part of home health services or an inpatient hospital stay;
- (8) Genotypic, phenotypic, or other HIV/AIDS drug resistance testing used in the treatment of HIV/AIDS, if the service is:
 - (a) Rendered by a Department-approved provider; and
 - (b) Medically necessary;
- (9) Except for those listed in Regulation .04D(4) of this chapter, drugs that are included in the SMHS formulary;
- (10) ICF-MR services;
- (11) Personal care services;
- (12) Medical day care services, for either adults or children;
- (13) Effective January 1, 2008, antiretroviral drugs in American Hospital Formulary Service therapeutic class 8:18:08 used in the treatment of HIV/AIDS;
- (14) Effective July 1, 2009, reimbursement for dental services for enrollees younger than 21 years old and pregnant women;
- (15) Transportation services provided through grants to local governments pursuant to COMAR 10.09.19;
- (16) Augmentative communication devices;
- (17) Cochlear implant devices for enrollees under 21 years old; and
- (18) Effective January 1, 2013, the facility and general anesthesia fees for dental surgery services for pregnant women and enrollees under 21 years old] *as described in COMAR 10.09.70.*

10.09.67.28 (7/14/14)

.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. Effective January 1, 2010, comprehensive substance abuse assessment (CSAA), as described in COMAR 10.09.65.11, once within a 12 month period per recipient per provider, unless there is more than a 30 day break in substance abuse treatment, if the following conditions are met:

- (1) The recipient is not currently in substance abuse treatment;
- (2) The assessment provider is certified by the Office of Health Care Quality (OHCQ) and meets the requirements established by the Alcohol and Drug Abuse Administration (ADAA) as described in COMAR 10.47;
- (3) The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law;

I. Effective January 1, 2010, substance abuse services:

- (1) That are provided by providers who meet the requirements specified in §H(2) of this regulation;
- (2) That the MCO determines are medically necessary for the enrollee according to the American Society of Addiction Medicine (ASAM) Patient Placement Criteria or are in accordance with the requirements established in §I(4) of this regulation;
- (3) When the substance abuse provider requests authorization within the notification requirements established by the Department; and
- (4) That include but are not limited to:
 - (a) A minimum of 3 days of inpatient detoxification in an acute care hospital if authorized as medically necessary by the MCO, or the number of days rendered before notification of denial based on medical necessity by the MCO;
 - (b) A minimum of 5 days of ambulatory detoxification if authorized as medically necessary by the MCO or the number of days rendered before notification of denial based on medical necessity by the MCO;
 - (c) Partial hospitalization as follows:
 - (i) A minimum of 2 days shall be covered automatically; and
 - (ii) If authorized as medically necessary by the MCO, additional days shall be covered;

(d) Methadone maintenance as follows:

(i) 26 weeks of out-of-plan methadone maintenance if authorized as medically necessary by the MCO or the number of weeks rendered before notification of denial based on medical necessity by the MCO; and

(ii) If authorized as medically necessary by the MCO, additional weeks of methadone maintenance shall be covered either in-plan or out-of-plan;

(e) 30 sessions of outpatient substance abuse treatment in a community-based substance abuse program, including individual, family, or group counseling within a 12 month period with additional sessions covered if authorized as medically necessary by the MCO;

(f) Intensive outpatient treatment provided in a community-based setting as follows:

(i) 30 days if authorized as medically necessary by the MCO or the number of days rendered before notification of denial based on medical necessity by the MCO; and

(ii) If authorized as medically necessary by the MCO, additional days or intensive outpatient treatment shall be covered either in-plan or out-of-plan; and

(g) For recipients younger than 21 years old, a minimum of 3 days provided in an Intermediate Care Facility-Addictions (ICF-A) if authorized:

(i) As medically necessary by the MCO or the number of days rendered before notification of denial based on medical necessity by the MCO;

(ii) As medically necessary by the MCO, additional days shall be covered;]

[J.] H.—[K] I. (text unchanged)

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Secretary of Health and Mental Hygiene