

MARYLAND REGISTER

Proposed Action on Regulations	
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	Date of Publication in MD Register

1. Desired date of publication in Maryland Register: July 14, 2023

2. COMAR Codification

Title	Subtitle	Chapter	Regulation
10	09	30	01
10	09	30	02
10	09	30	03
10	09	30	04
10	09	30	05
10	09	30	06
10	09	30	07
10	09	30	08
10	09	30	09
10	09	30	10

3. Promulgating Authority

Maryland Department of Health

4. Name of Regulations Coordinator

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6. Check applicable items:

- New Regulations
- Amendments to Existing Regulations
- Repeal of Existing Regulations
- Recodification
- Incorporation by Reference of Documents Requiring DSD Approval

7. Is there Emergency text that is identical to this Proposal:

Yes No

8. Incorporation by Reference

Incorporation by Reference (IBR) approval form(s) attached and 16 copies of documents proposed for incorporation submitted to DSD. (Submit 16 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 General Provisions Article, §3-302(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 Nicole Lugo Clark, Assistant Attorney General, telephone #410-767-5292, on October 07, 2022. A written copy of the approval is on file at this agency.

Name of Authorized Officer

Laura Herrera Scott

Title

Secretary of Health

Telephone No.

410-767-6500

Date

May 19, 2023

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.30 Statewide Evaluation and Planning Services

Notice of Proposed Action

[23-133-P]

The Secretary of Health proposes to:
adopt new Regulation .01, amend and recodify existing Regulations .01—.08 and .10 to be Regulations .02—.09 and .11, and recodify existing Regulation .09 to be Regulation .10 under COMAR 10.09.30 Statewide Evaluation and Planning Services.

Statement of Purpose

The purpose of this action is to clarify coverage for evaluation and planning services provided via telehealth to Medicaid participants by the Local Health Departments (LHD), or other contracted entities, in accordance with Senate Bill 3, Preserve Telehealth Access Act of 2021. The proposed action also aligns regulations with current practices associated with comprehensive evaluations by LHDs when performed to determine eligibility for services, inform individuals of available services, or as required for Geriatric Evaluation Services (GES) or Preadmission Screening and Resident Review (PASRR).

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 Jourdan Green, Director, Office of Regulation and Policy Coordination, Maryland Department of Health, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 TTY: 800-735-2258, or email to mdh.regs@maryland.gov. Comments will be accepted through August 14, 2023. A public hearing has not been scheduled.

LAURA HERRERA SCOTT
Secretary of Health

Economic Impact Statement Part C

A. Fiscal Year in which regulations will become effective: **FY 2023**

B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?

No

C. If 'yes', state whether general, special (exact name), or federal funds will be used:

undefined

D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:

N/A

E. If these regulations have no economic impact under Part A, indicate reason briefly:

The proposed changes will align the regulations with the Department's current practice and incorporate rates for additional types of comprehensive evaluations. The incorporation of additional rates does not represent a change in the rates themselves; therefore, there is no economic impact for Fiscal Year 2023 as compared to the previous fiscal year.

As the implementation of CFC reduces the scope of STEPS services, there may be an indeterminable amount of money, not to exceed \$50,000, saved due to the reorganizations of these services.

F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.

The proposed action impacts local health departments, which are not considered small businesses.

G. Small Business Worksheet:

N/A

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.30 [Statewide] *Comprehensive Evaluation and Planning Services*

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

.01 Purpose.

The purpose of these regulations is to codify policy regarding comprehensive evaluations performed for the purpose of determining eligibility for services, informing individuals of available services, or as required for Geriatric Evaluation Services (GES) or Preadmission Screening and Resident Review (PASRR).

[.01] .02 Definitions.

A. (text unchanged)

B. Terms Defined.

[(1) "Case management" means a service which will assist recipients in gaining access to:

(a) The full range of Medical Assistance services for which the individual is qualified; and

(b) Other needed support services such as medical, social, housing, financial, adult day care, in-home aide, and counseling.

(2) "Case manager" means a licensed registered nurse or licensed social worker, as defined in Regulation .02 of this chapter, who is employed by the STEPS provider to provide STEPS case management services and who is selected as case manager by the participant.]

[(3) (1) "Comprehensive evaluation" means the [determination] *assessment* performed by a nurse or social worker, or both, using the [uniform assessment form specified] *tools designated* by the Department, of a participant's medical, social, and functional status by:

(a)—(c) (text unchanged)

[(4) (2) (text unchanged)

[(5) (3) "Financial eligibility screening" means the determination of whether an individual qualifies financially as a [STEPS] participant.

[(6) "Medical Assistance Program" means a program of comprehensive medical and other health-related care for indigent and medically indigent persons.

(7) "Multidisciplinary assessment" means the review of the comprehensive evaluation and establishment of a recommended plan of care by the multidisciplinary team for the participant.

(8) "Multidisciplinary team" means the group composed of the nurse and social worker and, as appropriate, the participant or legally authorized representatives, or both, the participant's physician and providers of health related services.]

(4) "*Geriatric Evaluation Services (GES)*" means the assessment that is required to admit an individual to a State facility or Veteran's Administration hospital.

[(9) (5) (text unchanged)

[(10) "Participant" means:

(a) For the purposes of the STEPS comprehensive evaluation and multidisciplinary assessment, a recipient or an individual who would be able to establish financial eligibility under the Program within 6 months of admission to a nursing home and:

(i) Who is certified by the Department or its designee as requiring nursing home care under the Program pursuant to COMAR 10.09.10 or COMAR 10.09.11 or who, as determined by the STEPS provider based on the data collected in the comprehensive evaluation, requires services consistent with the Program's description of the level of care and types of services rendered in comprehensive care facilities reimbursed under the Program, including participants who would require inpatient care if community based long term care services were not available; and

(ii) Whose disabilities and needs cannot be adequately met in an episodic ambulatory care setting but who requires continuing institutional or community based long-term care services;

- (b) For the purposes of STEPS case management, a recipient who:
- (i) Is recommended for STEPS case management in the plan of care developed as part of the STEPS multidisciplinary assessment, because case management is considered necessary to enable the individual to gain access to services;
 - (ii) Chooses to receive STEPS case management;
 - (iii) Is not receiving the same case management services under a U.S. Department of Health and Human Services §1915(b) or §1915(c) waiver;
 - (iv) Does not reside in a long-term care institution; and
 - (v) Is not a hospital inpatient;]

(6) "Nurse practitioner" means a person who is licensed as a nurse practitioner in the jurisdiction in which services are provided.

(7) "Participant" means a Medicaid recipient or an individual who would be able to establish financial eligibility under the Program within 6 months of admission to a nursing facility, whose needs may not be adequately met in an episodic ambulatory care setting, and who may require continuing institutional or community based long-term care services.

[(11)] (8) "Plan of care" means the written long term care plan composed of a comprehensive evaluation [and multidisciplinary assessment] of the participant's health status including:

- (a) (text unchanged)
- (b) [Prognosis] *Psychosocial status*;
- (c) (text unchanged)
- (d) Type [and frequency] of services [required] *recommended*.

(9) "Preadmission Screening and Resident Review (PASRR)" means the screening or reviewing of all individuals with mental illness or intellectual disability who apply to or reside in Medicaid certified nursing facilities.

[(12)] (10) "Program" [means the Maryland Medical Assistance Program] *has the same meaning as defined in COMAR 10.09.36.*

[(13)] (11) "Provider" means a local health department, or when necessary, a contracted agency:

[a) For the purposes of the STEPS comprehensive evaluation and multidisciplinary assessment, a health services agency:]

[(i)] (a) Providing the [STEPS] comprehensive evaluation [and multidisciplinary assessment] through an appropriate agreement with the Department and identified as a Program provider by the issuance of an individual account number;

[(ii)] (b) Employing [licensed registered] nurses and [licensed] social workers to provide the [STEPS] comprehensive evaluation [and multidisciplinary assessment services]; and

[(iii)] (c) Demonstrating experience in providing assessment and evaluation services and in developing plans of care [for aged and chronically ill clients; and].

[(b) For the purposes of STEPS case management, a health services agency:

(i) Providing STEPS case management through an appropriate agreement with the Department and identified as a Program provider by the issuance of an individual account number;

(ii) Employing qualified licensed registered nurses and licensed social workers as case managers; and

(iii) Demonstrating experience in providing case management and in implementing plans of care for aged and chronically ill clients.]

[(14)] (12) (text unchanged)

[(15) "Recipient" means a person who is certified for, and is receiving, Medical Assistance benefits.]

(13) "Psychiatrist" means a person who is licensed as a psychiatrist in the jurisdiction in which services are provided.

(14) "Psychologist" means a person who is licensed as a psychologist in the jurisdiction in which services are provided.

[(16)] (15) "Social worker" means a person who is [in compliance with the social work licensing requirements] *licensed as a social worker* in the jurisdiction in which services are provided.

[(17) "Statewide Evaluation and Planning Services (STEPS)" means long term care evaluation and planning services including:

- (a) A comprehensive evaluation;
- (b) Multidisciplinary assessment including the establishment of the plan of care; and
- (c) Case management.]

[.02].03 Licensing Requirements.

A. Nurses performing STEPS shall be licensed pursuant to Health Occupations Article, §§7-101 and 7-301—7-315, Annotated Code of Maryland.

B. Social workers performing STEPS services shall be licensed pursuant to Health Occupations Article, §18-205, Annotated Code of Maryland.

C. Under this chapter, licensed registered nurses shall:

- (1) Have 2 years of community health nursing experience; or
- (2) Be directly supervised by a licensed registered nurse with 2 years of community health nursing experience.]

The following health professionals providing services under this regulation shall be licensed to practice in the jurisdiction in which services are rendered:

- (1) Nurses;
- (2) Nurse practitioners;
- (3) Psychiatrists;

- (4) *Psychologists; and*
- (5) *Social workers.*

[.03].04 Conditions for Participation.

[A. General requirements for participation in the Medical Assistance Program are that providers shall:

- (1) Ensure that employees performing STEPS meet the licensure requirements as provided in Regulation .02 of this chapter;
- (2) Apply for participation in the Program using the application form designated by the Department;
- (3) Be approved for participation by the Department;
- (4) Have a provider agreement in effect;
- (5) Verify the licenses and credentials of all professionals who are employed by, or who contract with, the provider of services;
- (6) Verify the eligibility of recipients;
- (7) Accept payment by the Program as payment in full for services rendered and make no additional charge to any person for STEPS specified under Regulation .04 of this chapter;
- (8) Provide services without discrimination on the basis of race, color, age, sex, national origin, marital status, physical or mental handicap;
- (9) Place no restrictions on a recipient's right to select among available health care providers;
- (10) Maintain adequate records for a minimum of 5 years, and make them available, upon request, to the Department or its designee;
- (11) Not knowingly employ or contract with a person, partnership, or corporation which has been disqualified from the Program to provide or supply service to Medical Assistance recipients, unless prior written approval has been received from the Department; and
- (12) Agree that claims rejected for payment due to late billing may not be billed to the participant.]

[B.] Specific requirements for participation in the Program are that [STEPS] providers shall:

- [(1) Meet the requirements of §A of this regulation;*
- (2) Have a written plan for the implementation of STEPS;*
- (3) Be available to participants at least 8 hours a day, 5 days a week and have established hours of daily operation, including after hours procedures for handling emergency cases;*
- (4) Have existing policies and procedures concerning the completion of STEPS functions that the provider in the provider agreement has agreed to perform;*
- (5) If approved as a provider of STEPS multidisciplinary assessments, develop procedures to expedite comprehensive evaluations when necessary, including the assurance that comprehensive evaluations for inpatients will be completed within 3 working days of an appropriate referral unless the client is not medically stable;*
- (6) If approved as a provider of STEPS multidisciplinary assessments, convene the multidisciplinary team for the participant which:*
 - (a) Assesses the appropriateness of institutional or community based long term care services for the participant,*
 - (b) Determines the medical, psychological, social, and functional status of each participant, and*
 - (c) Develops an individual plan of care reflecting both needed services and available services that are, or can be anticipated to be, rendered;]*

A. Ensure that all individuals performing services under Regulation .05 of this chapter meet the licensure requirements as provided in Regulation .03 of this chapter;

B. Have existing policies and procedures concerning the completion of comprehensive evaluations, and expedition of those evaluations when necessary, that the provider has agreed to perform;

[(7) C. Develop, as appropriate, [interagency, intra-agency and other] agreements in order to facilitate access to [long term care] services and coordinate with local public agencies and other providers [of long term care];

[(8) D. If approved as a provider of [STEPS multidisciplinary assessments] comprehensive evaluations, inform participants of the results of the [multidisciplinary assessment] comprehensive evaluation and of available [long term care] services; and

[(9) If approved as a provider of STEPS case management, provide case management covered services to recipients meeting the qualifications of STEPS case management participants.]

E. Ensure completion, at least every other year, of training on the tools designated by the Department for the purposes of the comprehensive evaluation, by all nurses and social workers providing services under this chapter.

[.04].05 Covered Services.

A. The Program reimburses for completed [STEPS] comprehensive evaluations [and multidisciplinary assessments], which include *assessment by a nurse, social worker, or both*[:].

(1) Performance of a comprehensive evaluation by a nurse or social worker, or both, not more than 5 working days after the date of an appropriate referral, unless the client is not medically stable, except as specified in Regulation .03B(5) of this chapter; and

(2) Completion of the multidisciplinary assessment not more than 10 working days after the date of the comprehensive evaluation.]

B. *The comprehensive evaluation or designated form is to be completed within the following timeframes:*

(1) 3 business days for all Geriatric Evaluation Services (GES) and Preadmission Screening and Resident Review (PASRR) for individuals transferring from a hospital to a nursing facility;

(2) 5 business days for all other PASRR; and

(3) 15 calendar days for all other purposes.

C. The comprehensive evaluation shall be completed in-person.

[B.] D. The Department will reimburse for the services listed in §A of this regulation when they are:

(1) Rendered to [qualified] participants [for STEPS comprehensive evaluations and multidisciplinary assessments] as defined in Regulation .02 of this chapter;

(2) Completed within the time-frame specified in [§A] §B of this regulation, unless [an] the Department is notified, in writing, of circumstances that prevent completion within the specified time frame and a temporary, alternative schedule has been approved by the Department [or documented client related circumstances prevent completion within the specified time limits];

(3) (text unchanged)

(4) Rendered by a provider approved to perform [STEPS] comprehensive evaluations [and multidisciplinary assessments].

[C. The Program reimburses for case management services which include:

(1) Discussing with the recipient the recommended plan of care from the STEPS multidisciplinary assessment and informing the recipient of the availability of the recommended services for which the recipient is potentially eligible.

(2) Arranging for the delivery of services by referring the recipient to qualified providers and negotiating with and securing service providers selected by the recipient.

(3) Following up promptly to insure that all services are in place and that the quantity and quality are sufficient to meet the recipient's need.

(4) Monitoring the recipient and the service provision on an ongoing basis. This activity includes regular telephone contact with the recipient, recipient's family or significant others, and service providers. The telephone contacts should occur as often as necessary but at least monthly. It also includes regularly scheduled home or in-person visits, at least quarterly.

(5) Providing assistance to service providers. This activity includes providing patient-specific information to service providers, with the participant's written consent, in order to help them provide appropriate care.

(6) Determining the participant's desire and continuing need for case management services, to enable the recipient to remain in the community. This determination is made not later than 60 days after management begins and at least every 6 months after the initial 60 days. As necessary, the plan of care is revised, with the participant's input. If the participant's condition changes significantly, arrangements shall be made for a STEPS reassessment.

D. In the 60-day period immediately following the STEPS multidisciplinary assessment, initial STEPS case management includes, as a unit of service, the initial encounter with the participant to establish a plan of care, as well as all other covered services necessary for implementation of the plan of care. After this initial 60-day period, ongoing care management activities include, as a unit of service, a monthly telephone contact with the participant and all other covered services necessary as part of the follow-up.

E. The Department will reimburse for the services listed in §C of this regulation when:

(1) Case management is recommended in the STEPS plan of care, as necessary to enable the individual to remain in the community, and the recipient chooses to receive these services;

(2) The STEPS case management provider and case manager are available to provide case management services not more than 3 working days after the receipt of the STEPS multidisciplinary assessment's plan of care recommendations and selection by the recipient as the provider and case manager;

(3) The services are rendered to qualified participants for STEPS case management;

(4) The services are adequately performed as reflected on the completed form specified by the Department and submitted to the Program as a condition for payment; and

(5) The services are rendered by a provider approved to perform STEPS case management.]

[.05].06 Limitations.

A. [STEPS] *The comprehensive evaluation* is advisory in nature and is designed to assist individuals in identifying and using appropriate long term care services.

B. A restriction may not be placed on the qualified recipient's option to receive the [STEPS multidisciplinary assessment or case management services] *comprehensive evaluation*.

C. [STEPS] *The comprehensive evaluation* does not restrict or otherwise affect:

(1)—(3) (text unchanged)

[D. STEPS services may not be reimbursed if they are:

(1) Provided as an integral and inseparable part of another covered Program service, since payment for case management is already included in payment for that service; or

(2) Provided as part of an institution's discharge planning.

E. Reimbursement may not be made for STEPS case management if the participant is receiving the same type of case management services under another Program authority.]

[.06].07 Payment Procedures.

A. Request for Payment.

(1)—(2) (text unchanged)

[(3) STEPS providers shall bill the Program the fee specified in §C of this regulation.]

B. (text unchanged)

C. [Payments. Payments shall be made:

(1) Only to a qualified STEPS provider as specified in these regulations;

(2) According to the following fee-for-service schedule for STEPS, effective July 1, 2011: Description Fee Per Unit of Service

(a) One completed STEPS comprehensive evaluation and multidisciplinary assessment \$370;

(b) One completed Medical Eligibility Review form (MDH 3871) for applicants to the Home and Community-Based Services Waiver for Older Adults under COMAR 10.09.54 and the Living at Home Program under COMAR 10.09.55 \$52;

(c) Initial STEPS case management (only one unit of service may be reimbursed during the initial 60 days following the beginning of STEPS case management)\$90;

(d) Other ongoing STEPS case management (only one unit of service may be reimbursed per month) \$15.]

Effective July 1, 2022, payments for comprehensive evaluations shall be made in accordance with the fee schedule below:

<i>When conducted for any purpose other than the Preadmission Screening and Resident Review (PASRR) using the Department's preferred tool</i>	<i>\$482.95</i>
<i>When conducted for the purpose of determining eligibility for any services that are not reimbursed by Medicaid or for the purpose of Geriatric Evaluation Services using the tool that is not preferred by the Department</i>	<i>\$370.00</i>
<i>When conducted for the purpose of PASRR and does not require a psychological or psychiatric review</i>	<i>\$370.00</i>
<i>When conducted for the purpose of PASRR and requires a psychological or psychiatric review</i>	<i>\$440.00</i>
<i>When conducted for the purpose of PASRR and requires a psychological and psychiatric review</i>	<i>\$510.00</i>
<i>When conducted for the purpose of PASRR and requires a psychological or psychiatric evaluation</i>	<i>\$570.00</i>
<i>When conducted for the purpose of PASRR and requires a psychological evaluation and a psychiatric review or a psychiatric evaluation and a psychological review</i>	<i>\$640.00</i>
<i>When conducted for the purpose of PASRR and requires both a psychological and psychiatric evaluation</i>	<i>\$770.00</i>

[.07].08 Recovery and Reimbursement.

[A. If the recipient has insurance or if any other person is obligated either legally or contractually to pay for, or to reimburse the recipient for, any service covered by this chapter, the provider shall seek payment from that source first. If payment is made by both the Program and the insurance or other source, the provider shall report, within 15 days after the close of each month, on a form designated by the Department, the amount paid by the Program, and the insurance or the other source, whichever is less, and refund the total amount of the lesser of the two payments reported to the Program at that time.

B. If refund of a payment as specified in §A, of this regulation, is not made, the Department will have the right to reduce its current payment to the provider by the amount of the duplicate payment, overpayment, or third-party payment.]

Recovery and reimbursement are as set forth in 10.09.36.07.

[.08].09 Cause for Suspension or Removal and Imposition of Sanctions.

[A. If the Department determines that a provider, any agent or employee of the provider, or any person with an ownership interest in the provider has failed to comply with the applicable federal or State laws or regulations, the Department may initiate one or more of the following actions against the responsible party:

- (1) Suspension from the Program;
- (2) Withholding of payment by the Program;
- (3) Removal from the Program; and
- (4) Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed.

B. If the Secretary of Health and Human Services suspends or removes a provider from participation in Medicare, the Department shall take similar action.

C. The Department shall give reasonable written notice to the provider of its intention to impose sanctions. The written notice shall state the effective date and specific reasons for the proposed action, and advise the provider of the right to appeal.

D. A provider who voluntarily withdraws from the Program or is removed or suspended from the Program according to this regulation shall notify recipients that he no longer honors Medical Assistance cards before he renders additional service.]

Cause for suspension or removal and imposition of sanctions are as set forth in COMAR 10.09.36.08.

[.10].11 Interpretive Regulation.

[Except when the language of a specific regulation indicates an intent by the Department to provide reimbursement for covered services to Program recipients without regard to the availability of federal financial participation, State regulations shall be interpreted in conformity with applicable federal statutes and regulations.]

Interpretive regulatory requirements are as set forth in COMAR 10.09.36.10.

Laura Herrera Scott
Secretary of Health