Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 61 Medical Day Care Services Waiver

Authority: Health-General Article, §§2-104(b), 15-103, and 15-111, Annotated Code of Maryland

01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Adult Evaluation and Review Services (AERS)" means an entity within the local health department which, in accordance with the waiver, this chapter, and COMAR 10.09.30, assesses waiver applicants and participants.

(2) "Authorized representative" means a spouse, legal guardian, parent, individual with power of attorney, or other individual designated in writing to the Department, authorized concerning the applicant's or recipient's eligibility under this chapter, to:

(a) Act on an applicant's or recipient's behalf; and

(b) Assist with the application or redetermination process and in other communication with the Department.

(3) "Centers for Medicare and Medicaid Services (CMS)" means the federal agency responsible for administering Medicare, Medicaid, and several other health related programs.

(4) "Department" means the Department of Health and Mental Hygiene.

(5) "Eligibility" means an individual's qualification for participation in the Medical Day Care Services Waiver, in accordance with the requirements of this chapter.

(6) "Eligible" means that an individual is determined to meet the requirements of this chapter for eligibility as a Medical Day Care Services Waiver participant.

(7) "Medicaid" means the Maryland Medical Assistance Program administered by the State of Maryland under Title XIX of the Social Security Act, which provides

comprehensive medical and other health-related care for categorically eligible and medically needy recipients.

(8) "Medical day care" means medically supervised, health-related services provided in an ambulatory setting to medically handicapped adults, who, because of their degree of impairment, need health maintenance and restorative services supportive to their community living.

(9) "Medical Day Care Services Waiver" means the program implemented under this chapter in accordance with the CMS-approved application for this waiver and any amendments to it submitted by the Department and approved by CMS.

(10) "Multidisciplinary team" means the group consisting of appropriate members of the medical day care center's professional staff, and the participant or authorized representative, or both, that establishes and updates the service plan and the plan of care and assesses the appropriateness of the services provided to the participant by the medical day care center.

(11) "Nursing facility" means a facility that is participating in the Maryland Medical Assistance Program as a nursing facility pursuant to COMAR 10.09.10.

(12) "Participant" means an individual who:

(a) Meets the qualifications for participation in the waiver as specified in Regulations .02 through .04 of this chapter; and

(b) Is enrolled by the Department to receive waiver services.

(13) "Personal physician" means an individual who:

(a) Is licensed to practice medicine under Health Occupations Article, Title 14, Annotated Code of Maryland; and

(b) Accepts primary medical responsibility for a recipient.

(14) "Plan of care" means a written plan established by the multidisciplinary team in accordance with:

(a) A signed physician order; and

(b) An assessment of the participant's health status and all of the participant's special care requirements necessary to maintain the participant at, or to restore the participant to, optimal capability for self care.

(15) "Program" means the Maryland Medical Assistance Program.

(16) "Provider" means a facility licensed under COMAR 10.12.04 furnishing medical day care services through an appropriate agreement with the Department, and identified as a Program provider by the issuance of an individual account number.

(17) "Recipient" means a person who is certified by the Department as eligible for, and is receiving, Medical Assistance benefits.

(18) "Service plan" means an approved document which specifies the type, amount, frequency, and duration of all waiver and other Medicaid services required to safely support the waiver participant in the community.

(19) "State Plan" means a comprehensive, written commitment by a State Medicaid agency, submitted under §1902(a) of the Social Security Act, to administer or supervise the administration of the Medical Assistance Program in accordance with federal requirements.

(20) "Supplemental Security Income (SSI)" means a federally administered program providing benefits to needy aged, blind, and disabled individuals under Title XVI of the Social Security Act, 42 U.S.C. §1381 et seq.

(21) "Waiver" means the Medical Day Care Services Waiver as implemented through this chapter.

(22) "Waiver applicant" means an individual who is applying for participation in the waiver to receive the services covered under this chapter.

(23) "Waiver year" means the State fiscal year from July 1 through June 30.

.02 Medical Assistance Eligibility.

A. Categorically Needy. An individual is eligible for waiver services as categorically needy if the individual is receiving Medical Assistance as a:

(1) Recipient of Supplemental Security Income (SSI);

(2) Member of a low income family with children, as described in §1931 of the Social Security Act; or

(3) Recipient eligible in another mandatory or optional categorically needy coverage group covered in the community under the State Plan.

B. Medically Needy. An individual is eligible for waiver services as medically needy if the individual is receiving Medical Assistance as an aged, blind, or disabled medically needy individual in accordance with COMAR 10.09.24.03D and .09.

C. An individual is not eligible to receive waiver services if a disposal of assets or establishment of a trust or annuity results in a penalty under COMAR 10.09.24, until such time as the penalty period expires.

03 Participant Eligibility.

A. Medical Eligibility.

(1) To be eligible for the services covered under COMAR 10.09.07, a waiver applicant or participant shall be certified by the Department or its designee as needing nursing facility services, pursuant to COMAR 10.09.10.

(2) The initial assessment for enrollment to the Program shall be conducted by AERS and submitted to the Department or its designee for certification.

(3) For the purpose of enrollment, the assessment of the applicant's need for nursing facility services is valid for 90 days.

(4) The Department or its designee shall annually certify as medically eligible only those financially eligible participants who require nursing facility services as defined under COMAR 10.09.10.

(5) The annual continued stay assessment shall be conducted by the medical day care provider's nursing staff or, at the discretion of the Department, by the Department's designee, with an assessment instrument approved by the Department and submitted to the Department or its designee for certification.

B. Technical Eligibility. An individual shall be determined by the Department or its designee to be eligible for waiver services if the individual:

(1) Is 16 years old or older;

(2) Is not enrolled simultaneously in both the Medical Day Care Services Waiver, and:

(a) Another Medicaid home and community-based services waiver under §1915(c) of the Social Security Act;

(b) Programs of All-Inclusive Care for the Elderly (PACE); or

(c) A Medicaid capitated program that includes nursing facility or community-based long term care services;

(3) Has a service plan that:

(a) Recommends medical day care services at least one time per week based on a physician's order;

(b) Is based on an initial or continued stay assessment approved by the Department or its designee;

(c) Is developed and signed by the participant or authorized representative, and an appropriately constituted multidisciplinary team, and approved by the Department or its designee;

(d) Is revised as necessary by the participant or authorized representative, and the multidisciplinary team due to a significant change in the participant's condition or service needs, with the revisions approved by the Department or its designee;

(e) Is reviewed at least annually by the participant or authorized representative and the multidisciplinary team to:

(i) Determine the appropriateness and adequacy of the services; and

(ii) Ensure that the services furnished are consistent with the nature and severity of the participant's condition and with the plan of care;

(4) Is determined by the Department or its designee as appropriate for home and community-based care;

(5) Is informed of feasible alternatives to nursing facility services that are available under the waiver;

(6) Is offered the choice between waiver and nursing facility services; and

(7) Chooses, or the individual's authorized representative chooses on the individual's behalf, to receive waiver services.

.04 Waiver Eligibility.

A. Based on the criteria established in Regulations .02 and .03 of this chapter, an applicant's eligibility for services under this chapter shall be established by the Department, and waiver eligibility may not begin before the latest of the following five dates:

(1) Waiver application date;

(2) Effective date of medical certification for the waiver's institutional level of care;

(3) Date that the applicant's written waiver service plan is established;

(4) Date that the applicant or representative signed a form designated by the Department to indicate the choice of waiver services as an alternative to institutionalization; or

(5) Date of the applicant's discharge from institutionalization in a long term care facility, if applicable.

B. The Department or its designee shall reevaluate a participant's eligibility for waiver services annually.

C. A participant shall be terminated from participation in the waiver as of the effective date of ineligibility as determined by the Department if the participant:

(1) No longer meets the eligibility requirements specified in Regulations .02 and .03 of this chapter;

(2) Voluntarily chooses, or the participant's authorized representative chooses on the participant's behalf, to disenroll from the waiver;

(3) Moves to another state;

(4) Is an inpatient for 30 consecutive days or more in a chronic hospital or nursing facility;

(5) Does not receive waiver services for 90 consecutive days; or

(6) Dies.

D. Reenrollment in the Waiver. If an individual is terminated from the waiver, the same individual may reenroll in the waiver during the same waiver year, if the individual meets all of the eligibility requirements of the waiver.

.05 Annual Cap and Registry for Waiver Participation.

A. For each State fiscal year beginning on July 1, the Department shall establish a cap, approved by CMS, for the number of unduplicated individuals who may receive the services covered under this chapter, based on available State and federal funding.

B. The annual cap for waiver participation may be revised, based on the Department's updated estimates of participants' Program expenditures for the State fiscal year, as compared with the available funding.

C. Eligible individuals shall be enrolled in the waiver program on a first-come, first-served basis until the annual cap on waiver participation is reached.

D. Once the annual cap on waiver participation is reached:

(1) A registry shall be established for individuals interested in applying for waiver services; and

(2) Individuals on the registry shall have an opportunity to apply for the waiver as openings become available.

.06 Conditions for Provider Participation.

A. Conditions for provider participation are those set forth in COMAR 10.09.07.

B. Providers shall maintain a service plan for each participant that includes:

(1) Name, address, and telephone number of the participant;

(2) Medical Assistance number of the participant;

(3) Name and telephone number of the participant's personal physician and of any managed care organization with which the participant is enrolled;

(4) Dated signatures of the participant or authorized representative, and each of the other individuals participating on the multidisciplinary team;

(5) A statement that the participant or authorized representative shall have access to the individual's medical day care services plan of care;

(6) A statement that enrollment is voluntary, but that the participant or the participant's caregiver shall notify the medical day care center when the participant is unable to attend;

(7) Authorization and frequency of attendance of medical day care services;

(8) Names of provider or providers that render waiver or State Plan services; and

(9) Approval by the Department or its designee.

07 Covered Services.

Covered services are those set forth in COMAR 10.09.07.

08 Limitations.

Limitations are those set forth in COMAR 10.09.07.

09 Payment Procedures.

Payment procedures are those set forth in COMAR 10.09.07.

10 Appeal Procedures for Applicants and Participants.

Appeal procedures for applicants and participants are those set forth in COMAR 10.09.24.13 and 10.01.04.

.11 Cause for Suspension or Removal and Imposition of Sanctions.

A. Cause for suspension or removal and imposition of sanctions for providers shall be in accordance with COMAR 10.09.36.

B. If the Department determines that a provider has failed to accurately assess the rehabilitative, cognitive, behavioral, and functional abilities and deficits, or medical service needs of an applicant or consumer, and to accurately convey such an assessment to the Department for purposes of obtaining an authorization to provide medical day care services, the Department shall:

(1) Suspend all eligibility decisions based upon assessments submitted by the provider until such time as the provider's assessment is validated by an independent assessment conducted by the Department's utilization control agent or the Department's designee; and

(2) Conduct remedial training of provider staff in accurately assessing rehabilitative, cognitive, behavioral, and functional abilities and deficits, or medical service needs, and in accurately conveying such assessments to the Department or its designee for purposes of establishing medical eligibility for medical day care service.

.12 Interpretive Regulation.

State regulations are interpreted as set forth in COMAR 10.09.36.10.

Administrative History

Effective date:

Regulations .01—.12 adopted as an emergency provision effective July 1, 2008 (35:17 Md. R. 1482); adopted permanently effective October 6, 2008 (35:20 Md. R. 1775)