Maryland Register

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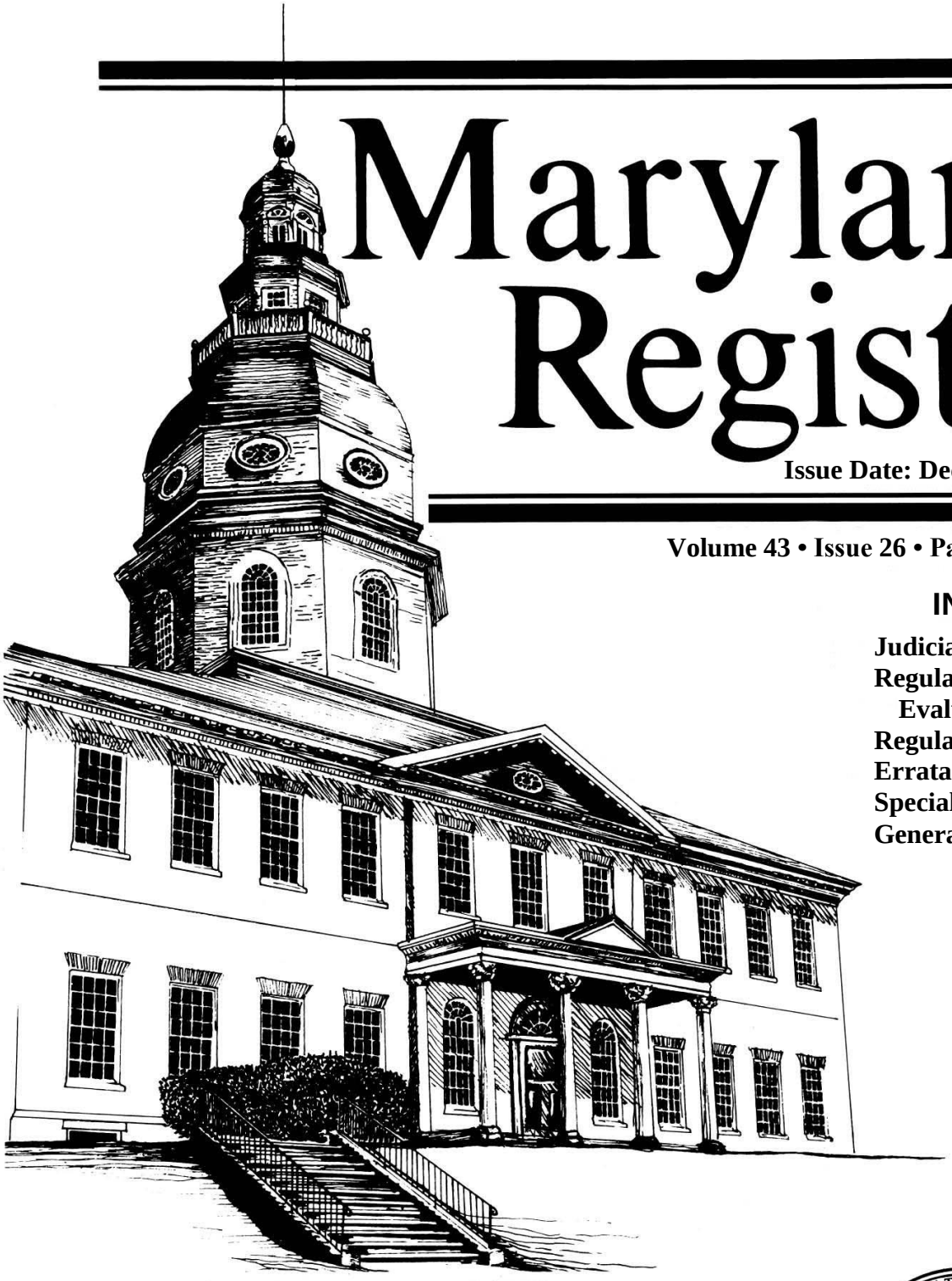

IN THIS ISSUE

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, this issue contains all previously unpublished documents required to be published, and filed on or before December 5, 2016, 5 p.m.

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, I hereby certify that this issue contains all documents required to be codified as of December 5, 2016.

Brian Morris
Administrator, Division of State Documents
Office of the Secretary of State

Information About the Maryland Register and COMAR

MARYLAND REGISTER

The Maryland Register is an official State publication published every other week throughout the year. A cumulative index is published quarterly.

The Maryland Register is the temporary supplement to the Code of Maryland Regulations. Any change to the text of regulations published in COMAR, whether by adoption, amendment, repeal, or emergency action, must first be published in the Register.

The following information is also published regularly in the Register:

- Governor's Executive Orders
- Attorney General's Opinions in full text
- Open Meetings Compliance Board Opinions in full text
- State Ethics Commission Opinions in full text
- Court Rules
- District Court Administrative Memoranda
- Courts of Appeal Hearing Calendars
- Agency Hearing and Meeting Notices
- Synopses of Bills Introduced and Enacted by the General Assembly
- Other documents considered to be in the public interest

CITATION TO THE MARYLAND REGISTER

The Maryland Register is cited by volume, issue, page number, and date. Example:

• 19:8 Md. R. 815—817 (April 17, 1992) refers to Volume 19, Issue 8, pages 815—817 of the Maryland Register issued on April 17, 1992.

CODE OF MARYLAND REGULATIONS (COMAR)

COMAR is the official compilation of all regulations issued by agencies of the State of Maryland. The Maryland Register is COMAR's temporary supplement, printing all changes to regulations as soon as they occur. At least once annually, the changes to regulations printed in the Maryland Register are incorporated into COMAR by means of permanent supplements.

CITATION TO COMAR REGULATIONS

COMAR regulations are cited by title number, subtitle number, chapter number, and regulation number. Example: COMAR 10.08.01.03 refers to Title 10, Subtitle 08, Chapter 01, Regulation 03.

DOCUMENTS INCORPORATED BY REFERENCE

Incorporation by reference is a legal device by which a document is made part of COMAR simply by referring to it. While the text of an incorporated document does not appear in COMAR, the provisions of the incorporated document are as fully enforceable as any other COMAR regulation. Each regulation that proposes to incorporate a document is identified in the Maryland Register by an Editor's Note. The Cumulative Table of COMAR Regulations Adopted, Amended or Repealed, found online, also identifies each regulation incorporating a document. Documents incorporated by reference are available for inspection in various depository libraries located throughout the State and at the Division of State Documents. These depositories are listed in the first issue of the Maryland Register published each year. For further information, call 410-974-2486.

HOW TO RESEARCH REGULATIONS

An Administrative History at the end of every COMAR chapter gives information about past changes to regulations. To determine if there have been any subsequent changes, check the ''Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed'' which is found online at http://www.dsd.state.md.us/PDF/CumulativeTable.pdf. This table lists the regulations in numerical order, by their COMAR number, followed by the citation to the Maryland Register in which the change occurred. The Maryland Register serves as a temporary supplement to COMAR, and the two publications must always be used together. A Research Guide for Maryland Regulations is available. For further information, call 410-260-3876.

SUBSCRIPTION INFORMATION

For subscription forms for the Maryland Register and COMAR, see the back pages of the Maryland Register. Single issues of the Maryland Register are $15.00 per issue.

CITIZEN PARTICIPATION IN THE REGULATION-MAKING PROCESS

Maryland citizens and other interested persons may participate in the process by which administrative regulations are adopted, amended, or repealed, and may also initiate the process by which the validity and applicability of regulations is determined. Listed below are some of the ways in which citizens may participate (references are to State Government Article (SG), Annotated Code of Maryland):

- By submitting data or views on proposed regulations either orally or in writing, to the proposing agency (see ''Opportunity for Public Comment'' at the beginning of all regulations appearing in the Proposed Action on Regulations section of the Maryland Register). (See SG, §10-112)
- By petitioning an agency to adopt, amend, or repeal regulations. The agency must respond to the petition. (See SG §10-123)
- By petitioning an agency to issue a declaratory ruling with respect to how any regulation, order, or statute enforced by the agency applies. (SG, Title 10, Subtitle 3)
- By petitioning the circuit court for a declaratory judgment on the validity of a regulation when it appears that the regulation interferes with or impairs the legal rights or privileges of the petitioner. (SG, §10-125)
- By inspecting a certified copy of any document filed with the Division of State Documents for publication in the Maryland Register. (See SG, §7-213)

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Lawrence J. Hogan, Jr., Governor; **John C. Wobensmith**, Secretary of State; **Brian Morris**, Administrator; **Gail S. Klakring**, Senior Editor; **Mary D. MacDonald**, Editor, Maryland Register and COMAR; **Elizabeth Ramsey**, Editor, COMAR Online, and Subscription Manager; **Tami Cathell**, Help Desk, COMAR and Maryland Register Online.

Front cover: State House, Annapolis, MD, built 1772—79.

Illustrations by Carolyn Anderson, Dept. of General Services

Contents

Closing Dates for the Maryland Register

COMAR Research Aids

Index of COMAR Titles Affected in This Issue

PERSONS WITH DISABILITIES

Individuals with disabilities who desire assistance in using the publications and services of the Division of State Documents are encouraged to call (410) 974-2486, or (800) 633-9657, or FAX to (410) 974-2546, or through Maryland Relay.

The Judiciary

Regulatory Review and Evaluation

Final Action on Regulations

Contents

Withdrawal of Regulations

Proposed Action on Regulations

Contents

Errata

Special Documents

General Notices

Contents

COMAR Online

The Code of Maryland Regulations is available at www.dsd.state.md.us as a free service of the Office of the Secretary of State, Division of State Documents. The full text of regulations is available and searchable. Note, however, that the printed COMAR continues to be the only official and enforceable version of COMAR.

The Maryland Register is also available at www.dsd.state.md.us.

For additional information, visit www.dsd.state.md.us, Division of State Documents, or call us at (410) 974-2486 or 1 (800) 633-9657.

Availability of Monthly List of Maryland Documents

The Maryland Department of Legislative Services receives copies of all publications issued by State officers and agencies. The Department prepares and distributes, for a fee, a list of these publications under the title ‘‘Maryland Documents’’. This list is published monthly, and contains bibliographic information concerning regular and special reports, bulletins, serials, periodicals, catalogues, and a variety of other State publications. ‘‘Maryland Documents’’ also includes local publications.

Anyone wishing to receive ‘‘Maryland Documents’’ should write to: Legislative Sales, Maryland Department of Legislative Services, 90 State Circle, Annapolis, MD 21401.

CLOSING DATES AND ISSUE DATES through JULY 21, 2017

Issue Date	Emergency and Proposed Regulations 5 p.m.*	Final Regulations 10:30 a.m.	Notices, etc. 10:30 a.m.
January 6**	December 19	December 28	December 23
January 20**	December 30	January 11	January 9
February 3**	January 13	January 25	January 23
February 17	January 30	February 8	February 6
March 3**	February 13	February 22	February 17
March 17	February 27	March 8	March 6
March 31	March 13	March 22	March 20
April 14	March 27	April 5	April 3
April 28	April 10	April 19	April 17
May 12	April 24	May 3	May 1
May 26	May 8	May 17	May 15
June 9**	May 22	May 31	May 26
June 23	June 5	June 14	June 12
July 7	June 19	June 28	June 26
July 21	July 3	July 12	July 10

* Due date for documents containing 8 to 18 pages — 48 hours before date shown; due date for documents exceeding 18 pages — 1 week before date shown

NOTE: ALL DOCUMENTS MUST BE SUBMITTED IN TIMES NEW ROMAN, 9-POINT, SINGLE-SPACED FORMAT. THE REVISED PAGE COUNT REFLECTS THIS FORMATTING.

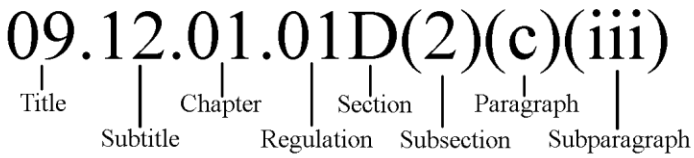
** Note closing date changes

*** Note issue date and closing date changes

The regular closing date for Proposals and Emergencies is Monday.

REGULATIONS CODIFICATION SYSTEM

Under the COMAR codification system, every regulation is assigned a unique four-part codification number by which it may be identified. All regulations found in COMAR are arranged by title. Each title is divided into numbered subtitles, each subtitle is divided into numbered chapters, and each chapter into numbered regulations.



A regulation may be divided into lettered sections, a section divided into numbered subsections, a subsection divided into lettered paragraphs, and a paragraph divided into numbered subparagraphs.

Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed

This table, previously printed in the Maryland Register lists the regulations, by COMAR title, that have been adopted, amended, or repealed in the Maryland Register since the regulations were originally published or last supplemented in the Code of Maryland Regulations (COMAR). The table is no longer printed here but may be found on the Division of State Documents website at www.dsd.state.md.us.

Table of Pending Proposals

The table below lists proposed changes to COMAR regulations. The proposed changes are listed by their COMAR number, followed by a citation to that issue of the Maryland Register in which the proposal appeared. Errata pertaining to proposed regulations are listed, followed by "(err)". Regulations referencing a document incorporated by reference are followed by "(ibr)". None of the proposals listed in this table have been adopted. A list of adopted proposals appears in the Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed.

02 OFFICE OF THE ATTORNEY GENERAL

02.06.03.01—.10 • 42:13 Md. R. 798 (6-26-15)

07 DEPARTMENT OF HUMAN RESOURCES

07.02.10.01,.02,.04,.09 • 43:26 Md. R. 1452 (12-23-16)
07.02.10.08,.18 • 43:24 Md. R. 1352 (11-28-16)
07.02.11.03,.05,.16 • 43:24 Md. R. 1353 (11-28-16)
07.02.14.01—.14 • 43:2 Md. R. 143 (1-22-16)
07.02.15.01—.11 • 43:17 Md. R. 964 (8-19-16)
07.02.17.03,.04,.06—.08 • 43:17 Md. R. 968 (8-19-16)
07.02.18.02,.04,.06—.14 • 43:17 Md. R. 969 (8-19-16)
07.02.19.01—.08,.10,.12—.14,.16 • 43:17 Md. R. 971 (8-19-16)

08 DEPARTMENT OF NATURAL RESOURCES

08.02.01.05 • 43:23 Md. R. 1282 (11-14-16)
08.02.01.09 • 43:25 Md. R. 1388 (12-9-16)
08.02.01.13 • 43:16 Md. R. 903 (8-5-16)
08.02.05.22 • 43:23 Md. R. 1283 (11-14-16)
08.02.10.01 • 43:23 Md. R. 1283 (11-14-16)
08.02.11.01,.04 • 43:25 Md. R. 1389 (12-9-16)
08.02.21.03 • 43:26 Md. R. 1453 (12-23-16)
08.03.01.01 • 43:16 Md. R. 904 (8-5-16)
08.04.16.01—.03 • 43:2 Md. R. 162 (1-22-16)

09 DEPARTMENT OF LABOR, LICENSING, AND REGULATION

09.12.43.02,.05 • 43:26 Md. R. 1452 (12-23-16)
09.35.02.02,.03 • 43:21 Md. R. 1170 (10-14-16)
09.38.01.01 • 43:18 Md. R. 1022 (9-2-16)

10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitles 01—08 (1st volume)

10.02.01.04 • 43:26 Md. R. 1454 (12-23-16)
10.03.01.08 • 43:23 Md. R. 1284 (11-14-16)
10.05.01.08 • 43:26 Md. R. 1457 (12-23-16)
10.05.03.04 • 43:26 Md. R. 1458 (12-23-16)
10.06.01.01,.02,.17,.18 • 43:26 Md. R. 1458 (12-23-16)
10.06.02.02,.04,.13 • 43:25 Md. R. 1392 (12-9-16)
10.07.01.01,.31 • 43:26 Md. R. 1460 (12-23-16)

Subtitle 09 (2nd volume)

10.09.01.01—.10 • 43:26 Md. R. 1462 (12-23-16)
10.09.02.07 • 43:26 Md. R. 1454 (12-23-16) (ibr)
10.09.06.01—.18 • 43:26 Md. R. 1464 (12-23-16)
10.09.08.04 • 43:26 Md. R. 1487 (12-23-16)
10.09.08.07,.10 • 43:26 Md. R. 1454 (12-23-16)
10.09.09.07 • 43:26 Md. R. 1454 (12-23-16)
10.09.14.07 • 43:25 Md. R. 1393 (12-9-16)
10.09.15.07 • 43:26 Md. R. 1454 (12-23-16)
10.09.17.06 • 43:25 Md. R. 1393 (12-9-16)
10.09.20.09—.11,.14 • 43:23 Md. R. 1284 (11-14-16)
10.09.21.01—.11 • 43:26 Md. R. 1462 (12-23-16)
10.09.23.01-1,.07 • 43:25 Md. R. 1393 (12-9-16) (ibr)
10.09.23.03 • 43:24 Md. R. 1354 (11-28-16)
10.09.24.08-2 • 43:26 Md. R. 1488 (12-23-16)
10.09.38.06 • 43:26 Md. R. 1454 (12-23-16)
10.09.39.01—.10 • 43:26 Md. R. 1462 (12-23-16)
10.09.49.11 • 43:26 Md. R. 1454 (12-23-16)
10.09.50.07 • 43:26 Md. R. 1454 (12-23-16)
10.09.51.07 • 43:25 Md. R. 1393 (12-9-16)
10.09.54.13—.19,.22 • 43:23 Md. R. 1285 (11-14-16)
10.09.60.01—.08 • 43:24 Md. R. 1355 (11-28-16)
10.09.62.01 • 43:26 Md. R. 1489 (12-23-16)
10.09.65.19 • 43:25 Md. R. 1394 (12-9-16)
10.09.65.19-3 • 43:24 Md. R. 1354 (11-28-16)

10.09.67.01,.07,.12 • 43:24 Md. R. 1354 (11-28-16)
10.09.67.20 • 43:26 Md. R. 1454 (12-23-16)
10.09.67.28 • 43:26 Md. R. 1489 (12-23-16)
10.09.68.01—.03 • 43:26 Md. R. 1489 (12-23-16)
10.09.70.02 • 43:25 Md. R. 1398 (12-9-16)
10.09.76.01—.11 • 43:26 Md. R. 1489 (12-23-16)
10.09.77.04,.06 • 43:26 Md. R. 1487 (12-23-16)
10.09.80.01,.05,.06,.08 • 43:25 Md. R. 1402 (12-9-16)
10.09.84.14—.20,.23,.24 • 43:23 Md. R. 1286 (11-14-16)
10.09.87.07 • 43:26 Md. R. 1454 (12-23-16)
10.09.88.07 • 43:26 Md. R. 1454 (12-23-16)
10.09.92.01—.14 • 43:26 Md. R. 1464 (12-23-16)
10.09.93.01—.16 • 43:26 Md. R. 1464 (12-23-16)
10.09.94.01—.13 • 43:26 Md. R. 1464 (12-23-16)
10.09.95.01—.13 • 43:26 Md. R. 1464 (12-23-16)

Subtitles 10 — 22 (3rd Volume)

10.11.03.14 • 43:26 Md. R. 1454 (12-23-16)
10.14.01.01,.02,.02-1,.07 • 43:25 Md. R. 1404 (12-9-16) (ibr)
10.14.06.02—.06 • 43:25 Md. R. 1406 (12-9-16)
10.15.05.01,.01-1,.13,.14,.20-1,.21,.24—.26-2 • 43:25 Md. R. 1407 (12-9-16) (ibr)
10.15.06.01-.07,.10,.12—.20 • 43:25 Md. R. 1407 (12-9-16)
10.15.08.02,.03 • 43:25 Md. R. 1407 (12-9-16)
10.16.07.03,.14 • 43:25 Md. R. 1415 (12-9-16)
10.18.04.01—.03 • 43:26 Md. R. 1458 (12-23-16)
10.21.25.03-2,.05—.13 • 43:19 Md. R. 1077 (9-16-16)
10.22.10.05 • 43:23 Md. R. 1287 (11-14-16)

Subtitles 23 — 36 (4th Volume)

10.24.15.01 • 43:25 Md. R. 1417 (12-9-16) (ibr)
10.24.19.01 • 43:18 Md. R. 1027 (9-2-16) (ibr)
10.27.01.04—.18 • 43:24 Md. R. 1357 (11-28-16)
10.27.21.02—.05,.07 • 43:25 Md. R. 1418 (12-9-16)
10.29.09.02—.06,.11,.14 • 43:26 Md. R. 1492 (12-23-16)
10.29.15.02—.05,.07,.08 • 43:26 Md. R. 1494 (12-23-16)
10.33.01.14 • 43:25 Md. R. 1419 (12-9-16)

Subtitles 37—65 (5th Volume)

10.37.10.03 • 43:20 Md. R. 1115 (9-30-16)
10.37.10.07-2 • 43:22 Md. R. 1244 (10-28-16)
10.38.12.01—.04 • 43:23 Md. R. 1287 (11-14-16)
10.39.01.03—.09 • 43:24 Md. R. 1357 (11-28-16)
10.39.04.04 • 43:24 Md. R. 1357 (11-28-16)
10.41.03.08 • 43:25 Md. R. 1420 (12-9-16)
10.41.08.02 • 43:25 Md. R. 1420 (12-9-16)
10.41.11.02 • 43:25 Md. R. 1420 (12-9-16)
10.48.01.07 • 43:26 Md. R. 1454 (12-23-16)
10.53.02.01—.10 • 43:24 Md. R. 1357 (11-28-16)
10.54.03.03,.04,.07—.11,.13—.16,.18,.19 • 43:26 Md. R. 1495 (12-23-16)
10.62.01.01 • 43:22 Md. R. 1245 (10-28-16)
10.62.08.03,.05—.07 • 43:22 Md. R. 1245 (10-28-16)
10.62.09.03 • 43:22 Md. R. 1245 (10-28-16)
10.62.12.02 • 43:22 Md. R. 1245 (10-28-16)
10.62.15.04—.07 • 43:22 Md. R. 1245 (10-28-16)
10.62.19.02,.04—.06 • 43:22 Md. R. 1245 (10-28-16)
10.62.20.03 • 43:22 Md. R. 1245 (10-28-16)
10.62.22.02 • 43:22 Md. R. 1245 (10-28-16)
10.62.25.03,.05—.07 • 43:22 Md. R. 1245 (10-28-16)
10.62.26.03 • 43:22 Md. R. 1245 (10-28-16)
10.62.28.02 • 43:22 Md. R. 1245 (10-28-16)
10.63.01.02,.04,.05 • 43:23 Md. R. 1289 (11-14-16)
10.63.03.14,.18,.19 • 43:23 Md. R. 1289 (11-14-16)
10.63.04.03 • 43:23 Md. R. 1289 (11-14-16)
10.63.06.10 • 43:23 Md. R. 1289 (11-14-16)

11 DEPARTMENT OF TRANSPORTATION

Subtitles 01—10

11.01.18.01,.02 • 43:22 Md. R. 1251 (10-28-16)

12 DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

12.04.01.01,.16 • 43:26 Md. R. 1500 (12-23-16)

13A STATE BOARD OF EDUCATION

13A.02.08.01—.03 • 43:22 Md. R. 1252 (10-28-16)
13A.03.07.01—.05 • 43:22 Md. R. 1252 (10-28-16)
13A.04.03.01—.11 • 43:22 Md. R. 1253 (10-28-16)
13A.04.19.01—.09 • 43:26 Md. R. 1502 (12-23-16)
13A.04.20.02,.04,.05,.07 • 43:26 Md. R. 1503 (12-23-16)
13A.06.07.01,.08—.10 • 43:26 Md. R. 1503 (12-23-16)
13A.07.11.01—.05 • 43:10 Md. R. 595 (5-13-16) (ibr)
13A.12.04.04 • 43:26 Md. R. 1505 (12-23-16)

13B MARYLAND HIGHER EDUCATION COMMISSION

13B.01.01.03,.15 • 43:25 Md. R. 1421 (12-9-16)
13B.02.02.08 • 43:25 Md. R. 1422 (12-9-16)
13B.05.01.05 • 43:25 Md. R. 1423 (12-9-16)
13B.05.01.06 • 43:25 Md. R. 1424 (12-9-16)
13B.06.01.02,.02-1,.04—.10 • 43:26 Md. R. 1505 (12-23-16)
13B.07.02.07 • 43:23 Md. R. 1290 (11-14-16)
13B.08.09.01—.11 • 42:22 Md. R. 1398 (10-30-15)
13B.08.13.01—.10 • 43:8 Md. R. 506 (4-15-16)
13B.08.14.01—.15 • 43:6 Md. R. 421 (3-18-16)
13B.08.15.01—.16 • 43:9 Md. R. 546 (4-29-16)

14 INDEPENDENT AGENCIES

14.06.03.05,.06 • 42:26 Md. R. 1638 (12-28-15)
14.35.01.01,.02 • 43:18 Md. R. 1039 (9-2-16)
14.35.07 • 43:19 Md. R. 1092 (9-16-16) (err)
14.35.07.01—.21 • 43:18 Md. R. 1039 (9-2-16)
14.36.04.01,.03—.08 • 43:4 Md. R. 342 (2-19-16)

15 DEPARTMENT OF AGRICULTURE

15.05.01.02 • 43:19 Md. R. 1088 (9-16-16)
15.06.04.06 • 43:21 Md. R. 1171 (10-14-16)

19A STATE ETHICS COMMISSION

19A.01.01.02,.04 • 43:20 Md. R. 1140 (9-30-16)
19A.01.02.02,.04 • 43:20 Md. R. 1140 (9-30-16)
19A.01.03.02,.04 • 43:20 Md. R. 1140 (9-30-16)
19A.04.Appendices A and B • 43:20 Md. R. 1140 (9-30-16)
19A.04.01.03 • 43:20 Md. R. 1140 (9-30-16)
19A.04.02.04,.05 • 43:20 Md. R. 1140 (9-30-16)
19A.04.03.01 • 43:20 Md. R. 1140 (9-30-16)
19A.05.Appendices A and B • 43:20 Md. R. 1140 (9-30-16)
19A.05.02.04,.06 • 43:20 Md. R. 1140 (9-30-16)
19A.06.01.03 • 43:20 Md. R. 1140 (9-30-16)

19A.06.02.04,.05 • 43:20 Md. R. 1140 (9-30-16)
19A.06.02.04,.05 • 43:20 Md. R. 1140 (9-30-16)
19A.06.03.05,.07 • 43:20 Md. R. 1140 (9-30-16)
19A.07.01.04,.06—.08 • 43:20 Md. R. 1140 (9-30-16)

20 PUBLIC SERVICE COMMISSION

20.31.01.02 • 43:23 Md. R. 1291 (11-14-16)
20.31.03.01 • 43:23 Md. R. 1291 (11-14-16)

26 DEPARTMENT OF THE ENVIRONMENT

Subtitles 01—07 (Part 1)

26.04.02.09 • 43:25 Md. R. 1424 (12-9-16)

Subtitles 08—12 (Part 2)

26.08.07.04 • 43:24 Md. R. 1361 (11-28-16)

Subtitles 19—27 (Part 4)

26.19.01.01—.61 • 43:23 Md. R. 1293 (11-14-16) (ibr)

29 DEPARTMENT OF STATE POLICE

29.01.02.01,.02,.11,.16 • 43:10 Md. R. 609 (5-13-16)
29.05.02.01—.08 • 43:12 Md. R. 693 (6-10-16)

30 MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS (MIEMSS)

30.08.15.03 • 43:23 Md. R. 1316 (11-14-16)

31 MARYLAND INSURANCE ADMINISTRATION

31.03.06.10 • 43:26 Md. R. 1508 (12-23-16)
31.14.01.13,.24,.36 • 43:26 Md. R. 1509 (12-23-16)
31.14.02.03—.06,.06-1 • 43:26 Md. R. 1509 (12-23-16)
31.04.15.03 • 43:25 Md. R. 1425 (12-9-16)
31.05.11.02 • 43:25 Md. R. 1425 (12-9-16)
31.05.12.01 • 43:25 Md. R. 1425 (12-9-16)
31.08.01.02 • 43:24 Md. R. 1362 (11-28-16)
31.08.02.02 • 43:24 Md. R. 1362 (11-28-16)
31.08.03 • 43:24 Md. R. 1362 (11-28-16)
31.08.08.07 • 43:24 Md. R. 1362 (11-28-16)
31.08.09.06—.08,.13,.14 • 43:24 Md. R. 1362 (11-28-16)
31.08.10.02 • 43:24 Md. R. 1362 (11-28-16)
31.08.13.03,.04,.06 • 43:20 Md. R. 1146 (9-30-16)
31.10.11.14 • 43:24 Md. R. 1365 (11-28-16)
31.13.01.22 • 43:23 Md. R. 1318 (11-14-16)
31.14.03.06 • 43:24 Md. R. 1365 (11-28-16)
31.15 • 43:2 Md. R. 128 (1-22-16) (err)
31.16.08.06 • 43:24 Md. R. 1366 (11-28-16)

33 STATE BOARD OF ELECTIONS

33.01.01.01 • 43:4 Md. R. 345 (2-19-16)
33.05.04.05 • 43:4 Md. R. 346 (2-19-16)
33.13.07.06 • 43:24 Md. R. 1367 (11-28-16)
33.13.08.06,.07 • 43:24 Md. R. 1367 (11-28-16)
33.13.10.02—.04 • 43:24 Md. R. 1367 (11-28-16)
33.13.13.08 • 43:24 Md. R. 1367 (11-28-16)
33.14.02.03 • 43:24 Md. R. 1369 (11-28-16)
33.16.01.01 • 43:4 Md. R. 346 (2-19-16)
33.16.02.05 • 43:4 Md. R. 346 (2-19-16)
33.16.03.01,.02 • 43:4 Md. R. 346 (2-19-16)
33.16.04.01 • 43:4 Md. R. 346 (2-19-16)
33.16.05.03,.04 • 43:4 Md. R. 346 (2-19-16)
33.16.06.01 • 43:4 Md. R. 346 (2-19-16)
33.20.06.01 • 43:24 Md. R. 1369 (11-28-16)

35 DEPARTMENT OF VETERANS' AFFAIRS

35.03.01.05 • 43:26 Md. R. 1515 (12-23-16)

The Judiciary

COURT OF APPEALS OF MARYLAND

DISCIPLINARY PROCEEDINGS

This is to certify that by an Order of the Court of Appeals dated December 6, 2016, **RICHARD WELLS MOORE, JR.**, 2300 York Road, Suite 213, Timonium, Maryland 21093, has been disbarred by consent, effective immediately, from the further practice of law in this State, and his name as an attorney at law has been stricken from the register of attorneys in this Court (Maryland Rule 19-761).

[16-26-31]

Regulatory Review and Evaluation

Regulations promulgated under the Administrative Procedure Act will undergo a review by the promulgating agency in accordance with the Regulatory Review and Evaluation Act (State Government Article, §§10-130 — 10-139; **COMAR 01.01.2003.20)**. This review will be documented in an evaluation report which will be submitted to the General Assembly's Joint Committee on Administrative, Executive, and Legislative Review. The evaluation reports have been spread over an 8-year period (see **COMAR 01.01.2003.20** for the schedule). Notice that an evaluation report is available for public inspection and comment will be published in this section of the Maryland Register.

Title 11
DEPARTMENT OF TRANSPORTATION

Notice of Opportunity for Comment

In accordance with the Regulatory Review and Evaluation Act, State Government Article, §§10-130—10-139, Annotated Code of Maryland, the Motor Vehicle Administration (MVA) is currently reviewing and evaluating the following chapters:

11.15.01 Gratis Registration Plates
11.15.02 Transporter Registration Plates
11.15.03 Recreational Vehicles
11.15.04 Class B Vehicle Requirements
11.15.05 Unorthodox Vehicles
11.15.06 Historic Motor Vehicles
11.15.07 Special Registration Number—Personalized Plates
11.15.08 Special Mobile Equipment
11.15.09 Temporary Registration
11.15.10 Amateur Radio Operator Registration Plates
11.15.11 Registration Transfer
11.15.12 Titling and Multiyear Registration for Fleet Vehicles
11.15.13 Issuance of a Nonresident Permit
11.15.14 Certificates of Title
11.15.15 Issuance of Chesapeake Bay Commemorative Plates
11.15.16 Issuance, Renewal, Display, and Expiration of Registrations
11.15.18 Vehicle Registration Issuance by State Agencies or Political Subdivisions Acting as Agent for Motor Vehicle Administration
11.15.19 Special Registration Numbers and Plates for Members of Certain Nonprofit Organizations
11.15.20 Dump Service Registration
11.15.21 Effect of Parking and Traffic Control Device Violations on Vehicle Registrations
11.15.22 Apportioned Registration of Fleet Vehicles
11.15.23 Special Registration Plates for Recipients of Combat-Related Armed Forces Medals and Honorably Discharged Veterans
11.15.24 Proportional Registration of Rental Vehicles
11.15.25 Certificate of Origin
11.15.26 Refund of Excise Tax
11.15.27 Four or More Axle Dump Service Vehicles
11.15.28 Vehicle Registration Suspension and Nonrenewal for Failure to Pay Toll
11.15.29 Rejection of Registration Plates
11.15.30 Issuance of Special Agricultural Registration Plates
11.15.31 Electronic Transmission of Titling and Registration Information
11.15.32 Low Speed Vehicles
11.15.33 Vehicle Trade-in Allowance
11.15.34 Salvage Vehicle Calculation
11.15.35 Mopeds, Motor Scooters, and Off-Highway Recreational Vehicles
11.16.01 Transportation of Hazardous Materials
11.16.02 Authorized Emergency and Service Vehicles
11.16.03 Personal Residential Permits for Reserved Parking Spaces for Permanently Disabled Persons
11.16.04 Revocation of Disabled Registration Plates and Parking Placards
11.17.01 Reexamination of Drivers
11.17.02 Expiration and Renewal of Driver's License
11.17.03 Physical and Mental Condition
11.17.04 Epilepsy - Restoration of License following Ineligibility
11.17.05 Use of Bioptic Telescopic Lenses
11.17.06 Identification Cards
11.17.08 Reinstatement of Revoked Driver's License or Privileges
11.17.09 Proof of Age, Name, Identity, Residence, and Lawful Status
11.17.11 Unauthorized Additions to Driver's License, Permit, or Photo Identification Card
11.17.12 Social Security Number
11.17.13 Point System: Definition of Moving Violation and of Points
11.17.14 Driver Knowledge and Skills Tests
11.17.15 Under 21 Alcohol Restriction
11.17.16 Corrected Driver's License
11.17.17 Provisional Driver's License
11.17.18 Disposition and Records of Traffic Citations: Citation Accountability
11.17.19 Issuance of Temporary Driver License Valid in Maryland Only
11.17.20 Emergency Vehicle—Requirements for certain License Exemptions
11.17.21 Proof of Age, Name, Identity, and Residency for Federally Noncompliant Driver Licenses and Identification Cards
11.18.01 Insurance Requirements
11.18.02 Self-Insurers
11.18.03 Adjustment of Uninsured Motorist Penalty Fee for Lapse of Insurance
11.18.04 Reporting Requirements for lapse or Termination of Required Security
11.19.01 Definitions Applicable to Type I and Type II School Vehicles
11.19.02 Type I School Vehicles—Construction Standards
11.19.03 Type II School Vehicles—Construction Standards
11.19.04 School Vehicles Inspection
11.19.05 School Vehicle Drivers
11.19.06 Use of Nonschool Vehicles by Schools or Licensed Child Care Centers
11.19.07 Testing of Equipment on School Vehicles
11.19.08 Certified School Vehicle Inspection Facilities for Vehicles 12 Years Old or Older

The purpose of this review and evaluation is to determine whether existing regulations continue to accomplish the purposes for which

they were adopted, clarify ambiguous or unclear language, and repeal obsolete or duplicative provisions. Pursuant to its work plan, MVA will evaluate the need to retain, amend, or repeal the regulations based on whether the regulations:

- Continue to be necessary for public interest;
- Continue to be supported by statutory authority and judicial opinions;
- Are obsolete or otherwise appropriate for amendment or repeal;
- Continue to be effective in accomplishing the intended purposes of the regulations

MDOT would like to provide interested parties with an opportunity to participate in the review and evaluation process by submitting comments on the regulations. The comments may address any concerns about the regulations. If the comments include suggested changes to the regulations, please be as specific as possible and provide language for the suggested changes. Comments must be received by January 23, 2017.

Comments should be directed to Tracey C. Sheffield, Regulations Coordinator, Motor Vehicle Administration, 6601 Ritchie Highway, N.E., Room 200, Glen Burnie, Maryland 21062 or by email to tsheffield@mdot.state.md.us.

[16-26-30]

Title 14
INDEPENDENT AGENCIES

Subtitle 27 MARYLAND ENVIRONMENTAL SERVICE

Notice of Opportunity for Public Inspection and Comment

In accordance with the Regulatory Review and Evaluation Act, State Government Article, §§10-130—10-138, Annotated Code of Maryland, the Maryland Environmental Service is currently reviewing and evaluating the following chapters under COMAR 14.27

COMAR 14.27.02 Human Resources
COMAR 14.27.03 Procurement
COMAR 14.27.04 Public Information Act Requests

Opportunity for Public Comment

The Maryland Environmental Service would like to provide interested parties with an opportunity to participate in the review and evaluation process and is requesting written public comments submitted by mail to Pamela Fuller, Paralegal, Maryland Environmental Service, 259 Najoles Road, Millersville, MD 21118, by fax at (410) 729-8220, or by email to pfull@menv.com. Comments must be received not later than February 28, 2017.

[16-26-14]

Final Action on Regulations

Symbol Key

- Roman type indicates text already existing at the time of the proposed action.
- *Italic type* indicates new text added at the time of proposed action.
- *Single underline, italic* indicates new text added at the time of final action.
- Single underline, roman indicates existing text added at the time of final action.
- [[Double brackets]] indicate text deleted at the time of final action.

Title 03 COMPTROLLER OF THE TREASURY

Subtitle 11 ONLINE FANTASY COMPETITIONS

03.11.01 General Provisions

Authority: Criminal Law Article, §12-114, Annotated Code of Maryland

Notice of Final Action

[16-215-F]

On December 7, 2016, the Comptroller of the Treasury adopted new Regulations **.01—.14** under a new chapter, **COMAR 03.11.01 Fantasy Sports Competition Regulations**, under a new subtitle, **Subtitle 11 Online Fantasy Competitions**. This action, which was proposed for adoption in 43:17 Md. R. 960—963 (August 19, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

PETER FRANCHOT
Comptroller

Title 08 DEPARTMENT OF NATURAL RESOURCES

Subtitle 03 WILDLIFE

08.03.10 General Wildlife Hunting Regulations

Authority: Natural Resources Article, §10-205, Annotated Code of Maryland

Notice of Final Action

[16-265-F]

On December 13, 2016, the Secretary of Natural Resources adopted the repeal of Regulation **.11** under **COMAR 08.03.10 General Wildlife Hunting Regulations**. This action, which was proposed for adoption in 43:22 Md. R. 1225 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

MARK J. BELTON
Secretary of Natural Resources

Subtitle 03 WILDLIFE

08.03.16 Hunting Privilege Suspension and Restitution

Authority: Natural Resources Article, §§10-1101.1, 10-1107, and 10-1108, Annotated Code of Maryland

Notice of Final Action

[16-266-F-I]

On December 13, 2016, the Secretary of Natural Resources adopted new Regulations **.01—.05** under **COMAR 08.03.16 Hunting Privilege Suspension and Restitution**. This action, which was proposed for adoption in 43:22 Md. R. 1225—1227 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

MARK J. BELTON
Secretary of Natural Resources

Title 09 DEPARTMENT OF LABOR, LICENSING, AND REGULATION

Subtitle 11 REAL ESTATE COMMISSION

09.11.09 Fees

Authority: Business Occupations and Professions Article, §17-213; Business Regulation Article, §2-106.4; Annotated Code of Maryland

Notice of Final Action

[16-151-F]

On October 19, 2016, the Real Estate Commission adopted amendments to Regulation **.02** under **COMAR 09.11.09 Fees**. This action, which was proposed for adoption in 43:13 Md. R. 721—722 (June 24, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

KATHIE CONNELLY
Executive Director
Real Estate Commission

Subtitle 12 DIVISION OF LABOR AND INDUSTRY

09.12.21 Employee Injury and Illness Records and Reports

Authority: Labor and Employment Article, §§2-106(b)(4), 5-312, and 5-702—5-704, Annotated Code of Maryland

Notice of Final Action

[16-269-F]

On December 12, 2016, the Commissioner of Labor and Industry adopted amendments to Regulation **.02** under **COMAR 09.12.21 Employee Injury and Illness Records and Reports**. This action, which was proposed for adoption in 43:22 Md. R. 1227—1228 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

THOMAS J. MEIGHEN
Commissioner of Labor and Industry

Subtitle 12 DIVISION OF LABOR AND INDUSTRY

09.12.31 Maryland Occupational Safety and Health Act — Incorporation by Reference of Federal Standards

Authority: Labor and Employment Article §§2-106(b)(4) and 5-312(b), Annotated Code of Maryland

Notice of Final Action

[16-051-F]

On December 12, 2016, the Commissioner of Labor and Industry adopted, through incorporation by reference under **COMAR 09.12.31 Maryland Occupational Safety and Health Act — Incorporation by Reference of Federal Standards**, amendments relating to Confined Spaces in Construction, 29 CFR Part 1926, published in 80 FR 25366 — 25526 (May 4, 2015).

This action, which was proposed for adoption in 43:2 Md. R. 176 (January 22, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

THOMAS J. MEIGHEN
Commissioner of Labor and Industry

Subtitle 12 DIVISION OF LABOR AND INDUSTRY

09.12.35 Maryland Occupational Safety and Health Standard for Confined Spaces

Authority: Labor and Employment Article, §§2-106(b)(4) and 5-312, Annotated Code of Maryland

Notice of Final Action

[16-279-F]

On December 12, 2016, the Commissioner of Labor and Industry adopted the repeal of Regulations **.01—.05** under **COMAR 09.12.35 Maryland Occupational Safety and Health Standard for Confined Spaces**. This action, which was proposed for adoption in 43:22 Md. R. 1228 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

THOMAS J. MEIGHEN
Commissioner of Labor and Industry

Subtitle 20 BOARD OF PLUMBING

09.20.01 State Plumbing Code

Authority: Business Occupations and Professions Article, §§12-205 and 12-207, Annotated Code of Maryland

Notice of Final Action

[16-196-F-I]

On October 20, 2016, the State Board of Plumbing adopted amendments to Regulations **.01 — .04** and new Regulation **.05** under **COMAR 09.20.01 State Plumbing Code**. This action, which was proposed for adoption in 43:16 Md. R. 904—909 (August 5, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

MICHAEL J. KASTNER, JR.
Chair
Board of Plumbing

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 15 FOOD

10.15.07 Shellfish Sanitation

Authority: Health-General Article, §§18-102, 21-211, 21-234, 21-304, 21-321, and 21-346—21-350, Annotated Code of Maryland

Notice of Final Action

[16-274-F-I]

On December 14, 2016, the Secretary of Health and Mental Hygiene adopted amendments to Regulation **.01** under **COMAR 10.15.07 Shellfish Sanitation**. This action, which was proposed for adoption in 43:22 Md. R. 1229 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 21 MENTAL HYGIENE REGULATIONS

10.21.01 Involuntary Admission to Inpatient Mental Health Facilities

Authority: Health-General Article, §§*7.5-204—7.5-205,* 10-616, *10-619, and 10-806(d)(3),* Annotated Code of Maryland

Notice of Final Action

[16-237-F]

On December 7, 2016, the Secretary of Health and Mental Hygiene adopted amendments to Regulations **.02** and **.04** under **COMAR 10.21.01 Involuntary Admission to Inpatient Mental Health Facilities**.

Also at this time, the Secretary is withdrawing the proposed amendments to Regulations **.08** and **.09** under **COMAR 10.21.01 Involuntary Admission to Inpatient Mental Health Facilities**, which were printed in the same Notice of Proposed Action.

This action, which was proposed for adoption in 43:19 Md. R. 1076—1077 (September 16, 2016), has otherwise been adopted as proposed.

Effective Date: January 2, 2017.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 21 MENTAL HYGIENE REGULATIONS

10.21.25 Fee Schedule — Mental Health Services — Community-Based Programs and Individual Practitioners

Authority: Health-General Article, §§10-901, 15-103, and 15-105; Title 16, Subtitles 1 and 2; Annotated Code of Maryland

Notice of Final Action

[16-280-F]

On December 14, 2016, the Secretary of Health and Mental Hygiene adopted amendments to Regulations **.03** and **.08** under **COMAR 10.21.25 Fee Schedule — Mental Health Services — Community-Based Programs and Individual Practitioners**. This action, which was proposed for adoption in 43:22 Md. R. 1229—1230 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 22 DEVELOPMENTAL DISABILITIES

10.22.17 Fee Payment System for Licensed Residential and Day Programs

Authority: Health-General Article, §§2-104(b), 7-306.1, *7-307,* 15-105, 15-107, and 16-201, Annotated Code of Maryland

Notice of Final Action

[16-270-F]

On December 14, 2016, the Secretary of Health and Mental Hygiene adopted amendments to Regulations **.06—.08** under **COMAR 10.22.17 Fee Payment System for Licensed Residential and Day Programs**. This action, which was proposed for adoption in 43:22 Md. R. 1230—1239 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 32 BOARD OF PHYSICIANS

Notice of Final Action

[16-275-F]

On December 14, 2016, the Secretary of Health and Mental Hygiene adopted amendments to:

(1) Regulations **.08**, **.10**, and **.11** under **COMAR 10.32.01 General Licensure Regulations**;

(2) Regulation **.09** under **COMAR 10.32.03 Delegation of Duties by a Licensed Physician — Physician Assistant**;

(3) Regulations **.07** and **.08 under COMAR 10.32.06 Licensure of Polysomnographic Technologists**;

(4) Regulation **.07** under **COMAR 10.32.08 Licensure of Athletic Trainers**;

(5) Regulation **.13** under **COMAR 10.32.10 Licensure of Radiation Therapists, Radiographers, Nuclear Medicine Technologists, and Radiologist Assistants**; and

(6) Regulations **.09** and **.11** under **COMAR 10.32.11 Licensing of Respiratory Care Practitioners**.

This action, which was proposed for adoption in 43:22 Md. R. 1239—1244 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Notice of Final Action

[16-250-F]

On December 9, 2016, the Secretary of Health and Mental Hygiene adopted:

(1) Amendments to the subtitle name under **COMAR 10.43 Board of Chiropractic Examiners**;

(2) Amendments to the chapter name under **COMAR 10.43.01 General Regulations**;

(3) Amendments to the chapter name and Regulations **.01—.03** under **COMAR 10.43.03 Advertising**;

(4) Amendments to Regulation **.01** under **COMAR 10.43.04 Licensure by Credentials for Chiropractors**;

(5) Amendments to Regulations **.02** and **.03** under **COMAR 10.43.05 Chiropractic Externship Program**;

(6) Amendments to the chapter name and the recodification of existing Regulations **.04—.05** to be Regulations **.03—.04** under **COMAR 10.43.06 Fees**;

(7) Amendments to Regulations **.01** and **.09** under **COMAR 10.43.07 Chiropractic Assistants**;

(8) Amendments to the chapter name under **COMAR 10.43.08 Licensure and Registration Examination—Special Needs Applicants**;

(9) The recodification of existing **COMAR 10.43.10** to be **COMAR 10.43.09**, amendments to the chapter name, and amendments to Regulation **.02** under **COMAR 10.43.09 Monetary Penalties**;

(10) The recodification of existing **COMAR 10.43.11** to be **COMAR 10.43.10**, amendments to the chapter name, and amendments to Regulation **.02** under **COMAR 10.43.10 Continuing Education Requirements**;

(11) The recodification of existing **COMAR 10.43.12** to be **COMAR 10.43.11**, amendments to the chapter name, and amendments to Regulation **.02** under **COMAR 10.43.11 Licensure Examination**;

(12) The recodification of existing **COMAR 10.43.13** to be **COMAR 10.43.12** and amendments to the chapter name under **COMAR 10.43.12 Procedures for Clinical Demonstrations in Public Places**;

(13) The recodification of existing **COMAR 10.43.14** to be **COMAR 10.43.13** and amendments to the chapter name under **COMAR 10.43.13 Code of Ethics**;

(14) The recodification of existing **COMAR 10.43.15** to be **COMAR 10.43.14**, amendments to the chapter name, and amendments to Regulation **.02** under **COMAR 10.43.14 Record Keeping**;

(15) The recodification of existing **COMAR 10.43.16** to be **COMAR 10.43.15**, amendments to the chapter name, and amendments to Regulation **.02** under **COMAR 10.43.15 Sanctioning Guidelines**;

(16) New **Subtitle 65** under **COMAR 10.65 Board of Massage Therapy Examiners**;

(17) The recodification of existing **COMAR 10.43.17** to be **COMAR 10.65.01**, amendments to the chapter name, new Regulations **.01** and **.02**, the recodification of existing Regulations **.01**, **.05**, and **.07** to be Regulations **.03**, **.07**, and **.09**, amendments to and the recodification of existing Regulations **.02—.04**, **.06** and **.08—.10** to be Regulations **.04—.06**, **.08**, and **.10—.12**, and the recodification of existing Regulations **.11** and **.12** to be Regulations **.13** and **.14** under a new chapter, **COMAR 10.65.01 General Regulations**;

(18) New Regulations **.01—.09** under a new chapter, **COMAR 10.65.02 Rules of Procedure for Board Hearings**;

(19) The recodification of existing **COMAR 10.43.18** to be **COMAR 10.65.03**, amendments to the chapter name, and amendments to Regulations **.03** and **.09** under a new chapter, **COMAR 10.65.03 Code of Ethics**;

(20) The recodification of existing **COMAR 10.43.19** to be **COMAR 10.65.04**, amendments to the chapter name, and amendments to Regulations **.01—.03** and **.06** under a new chapter, **COMAR 10.65.04 Advertising**;

(21) The recodification of existing **COMAR 10.43.20** to be **COMAR 10.65.05** and amendments to the chapter name under a new chapter, **COMAR 10.65.05 Continuing Education Requirements**;

(22) The recodification of existing **COMAR 10.43.21** to be **COMAR 10.65.06** and amendments to the chapter name under a new chapter, **COMAR 10.65.06 Record Keeping**;

(23) New Regulations **.01** and **.03—.04** and the recodification of existing Regulation **.03** under **COMAR 10.43.06** to be Regulation **.02** under a new chapter, **COMAR 10.65.07 Fees**;

(24) New Regulations **.01** and **.02** under a new chapter, **COMAR 10.65.08 Licensure and Registration Examination—Special Needs Applicants**; and

(25) New Regulations **.01—.06** under a new chapter, **COMAR 10.65.09 Sanctioning Guidelines**.

This action, which was proposed for adoption in 43:20 Md. R. 1117—1128 (September 30, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 44 BOARD OF DENTAL EXAMINERS

10.44.20 Fees

Authority: Health Occupations Article, §4-505, Annotated Code of Maryland

Notice of Final Action

[16-272-F]

On December 14, 2016, the Secretary of Health and Mental Hygiene adopted amendments to Regulation **.02** under **COMAR 10.44.20 Fees**. This action, which was proposed for adoption in 43:22 Md. R. 1245 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Title 12
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

Subtitle 14 COMMISSION ON CORRECTIONAL STANDARDS

Notice of Final Action

[16-252-F]

On November 21, 2016, the Secretary of Public Safety and Correctional Services, in cooperation with the Commission on Correctional Standards, adopted amendments to:

(1) Regulations **.02**, **.03**, **.06**, and **.09** under **COMAR 12.14.03 Minimum Standards for Adult Detention Centers**;

(2) Regulations **.01**, **.02**, **.05**, and **.08** under **COMAR 12.14.04 Minimum Standards for Adult Correctional Institutions**; and

(3) Regulations **.01**, **.02**, **.05**, and **.08** under **COMAR 12.14.05 Minimum Standards for Adult Community Correctional Facilities**.

This action, which was proposed for adoption in 43:20 Md. R. 1136—1138 (September 30, 2016), has been adopted as proposed.

Effective Date: April 1, 2017.

STEPHEN T. MOYER
Secretary of Public Safety and Correctional Services

Title 13A
STATE BOARD OF EDUCATION

Subtitle 04 SPECIFIC SUBJECTS

13A.04.10 Program of Instruction in *Career Development for College and Career Readiness*

Authority: Education Article, §2-205, Annotated Code of Maryland

Notice of Final Action

[16-236-F]

On December 5, 2016, the Maryland State Board of Education adopted amendments to Regulations **.01** and **.02** under **COMAR 13A.04.10 Program of Instruction in Career Development for College and Career Readiness**. This action, which was proposed for adoption in 43:19 Md. R. 1085—1086 (September 16, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Subtitle 05 SPECIAL INSTRUCTIONAL PROGRAMS

13A.05.01 Provision of a Free Appropriate Public Education

Authority: Education Article, §§2-205, 7-305, 8-301—8-307, *8-3A-01—8-3A-08*, and 8-401—8-416; Human Services Article, §§8-401—8-409; Labor and Employment Article, §§11-801 and 11-901 et seq.; State Government Article §9-1607.1; Annotated Code of Maryland
Federal Statutory Reference: 20 U.S.C. §§1411—1416; Federal Regulatory References: 34 CFR 300, 301, and 99

Notice of Final Action

[16-259-F]

On December 5, 2016, the Maryland State Board of Education adopted amendments to Regulations **.03** and **.05—.08** under **COMAR 13A.05.01 Provision of a Free Appropriate Public Education**. This action, which was proposed for adoption in 43:20 Md. R. 1138—1139 (September 30, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Subtitle 05 SPECIAL INSTRUCTIONAL PROGRAMS

13A.05.03 Programs of Adult Education

Authority: Education Article, *§2-205,* Annotated Code of Maryland

Notice of Final Action

[16-235-F]

On December 5, 2016, the Maryland State Board of Education adopted the repeal of Regulations **.01—.03** under **COMAR 13A.05.03 Programs of Adult Education**. This action, which was proposed for adoption in 43:19 Md. R. 1086 (September 16, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Subtitle 05 SPECIAL INSTRUCTIONAL PROGRAMS

13A.05.08 Approved Paid Work-Based Learning Programs

Authority: Education Article, *§2-205,* Annotated Code of Maryland

Notice of Final Action

[16-234-F]

On December 5, 2016, the Maryland State Board of Education adopted the repeal of Regulations **.01—.06** under **COMAR 13A.05.08 Approved Paid Work-Based Learning Programs**. This action, which was proposed for adoption in 43:19 Md. R. 1086—1087 (September 16, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Subtitle 05 SPECIAL INSTRUCTIONAL PROGRAMS

13A.05.12 Hearing Aid Loan Bank

Authority: Education Article, §§2-205 and 8-605, Annotated Code of Maryland

Notice of Final Action

[16-233-F]

On December 5, 2016, the Maryland State Board of Education adopted new Regulations **.01—.03** under new chapter, **COMAR 13A.05.12 Hearing Aid Loan Bank**. This action, which was proposed for adoption in 43:19 Md. R. 1087—1088 (September 16, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Title 15 DEPARTMENT OF AGRICULTURE

Subtitle 20 SOIL AND WATER CONSERVATION

15.20.07 Agricultural Operation Nutrient Management Plan Requirements

Authority: Agriculture Article, §§ 8-801—8-806, Annotated Code of Maryland

Notice of Final Action

[16-268-F-I]

On December 13, 2016, the Secretary of Agriculture adopted amendments to Regulation **.02** under **COMAR 15.20.07 Agricultural Operation Nutrient Management Plan Requirements**. This action, which was proposed for adoption in 43:22 Md. R. 1254 (October 28, 2016), has been adopted with the nonsubstantive changes shown below.

Effective Date: January 2, 2017.

Attorney General's Certification

In accordance with State Government Article, §10-113, Annotated Code of Maryland, the Attorney General certifies that the following changes do not differ substantively from the proposed text. The nature of the changes and the basis for this conclusion are as follows:

The following changes correct a spelling error and provide two cross-references to clarify an exception to the winter prohibition against the application of nutrients to agricultural land and nutrient management standards governing emergency applications of organic fertilizer.

E. Prohibition against Winter Application

1. Except as provided in subsections E.2, E.3 and E.4, after July 1, 2016, a person may not make a winter application of a nutrient source to agricultural land.

2. a. The prohibition against making a winter application after July 1, 2016 does not apply to a nutrient source that originates from:

(i) A dairy or livestock operation with less than 50 animal units; or

(ii) A municipal wastewater treatment plant with a design flow capacity of less than 0.5 million gallons per day.

b. This exception to the general prohibition referenced in subsection E.1 expires after the winter application that ends on February 28, 2020.

3. The prohibition against making a winter application does not apply to potash, liming materials, or manure deposited directly by livestock. A person may make a winter application of certain nutrients for greenhouse production and for certain vegetable crops, small fruit crops, small grain crops, and cool season grass sod production listed in the Maryland Nutrient Management Manual Section I-B.

4. Applications required in emergency situations due to an imminent overflow of a storage facility from on farm generated organic fertilizer shall be managed as provided in III D.2 in consultation with the Maryland Department of Agriculture. Operators in such situations shall contact the MDA regional nutrient management representative for guidance. Operators will be required to enter into an agreement of intent with the Soil Conservation District or private entity that is a certified Technical Service Provider approved by NRCS.

JOSEPH BARTENFELDER
Secretary of Agriculture

Title 18
DEPARTMENT OF ASSESSMENTS AND TAXATION

Subtitle 04 BUSINESS ORGANIZATIONS

18.04.11 Prohibited Filings

Authority: Corporations and Associations Article, §1-201.1(c), Annotated Code of Maryland

Notice of Final Action

[16-273-F]

On December 14, 2016, the Director of the Department of Assessments and Taxation adopted new Regulation **.01** under a new chapter, **COMAR 18.04.11 Prohibited Filings**. This action, which was proposed for adoption in 43:22 Md. R. 1255 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

SEAN P. POWELL
Director of Assessments and Taxation

Title 21
STATE PROCUREMENT REGULATIONS

Notice of Final Action

[16-261-F]

On December 7, 2016, the Board of Public Works adopted:

(1) Amendments to Regulation **.01** under **COMAR 21.01.02 Terminology**;

(2) Amendments to Regulation **.04** under **COMAR 21.02.01 Board of Public Works**;

(3) Amendments to Regulations **.02** and **.03** under **COMAR 21.02.03 Department of Budget and Management**;

(4) Amendments to Regulation **.03** under **COMAR 21.04.01 General Policies**;

(5) Amendments to Regulation **.01** under **COMAR 21.05.01 General Provisions**;

(6) Amendments to Regulation **.04** under **COMAR 21.05.05 Sole Source Procurement**;

(7) Amendments to Regulations **.04**, **.07**, and **.08** under **COMAR 21.05.08 Mandatory Written Solicitation Requirements**;

(8) New Regulations **.01—.07** under a new chapter, **COMAR 21.05.12 Procurement of Human, Social, Cultural, and Educational Services**.

(9) Amendments to Regulations **.09** and **.10** under **COMAR 21.06.07 Bid and Contract Security/Bonds**;

(10) New Regulations **.01—.06** under a new chapter, **COMAR 21.06.09 Invoicing, Payment, and Interest on Late Payments**;

(11) Amendments to Regulations **.08**, **.18**, **.20**, **.25**, and **.26** under **COMAR 21.07.01 Mandatory Contract Provisions—All Contracts (except as provided under COMAR 21.05.07, 21.07.02, and 21.07.03)**;

(12) Amendments to Regulation **.04** under **COMAR 21.07.02 Mandatory Construction Contract Clauses**;

(13) Amendments to Regulation **.09** under **COMAR 21.11.03 Minority Business Enterprise Policies**;

(14) Amendments to Regulations **.01** and **.02** under **COMAR 21.11.09 Vending Facilities on Property Controlled by Department of General Services**;

(15) Amendments to Regulations **.02** and **.04** under **COMAR 21.11.13 Veteran-Owned Small Business Enterprises**;

(16) Amendments to Regulations **.10** and **.10-1** under **COMAR 21.12.04 Department of General Services; A/E Services Exceeding $200,000**;

(17) Amendments to Regulation **.01** under **COMAR 21.12.05 Department of General Services; A/E Services $200,000 or Less**; and

(18) The repeal of existing Regulations **.01—.07** under **COMAR 21.14.01 General Regulations**.

This action, which was proposed for adoption in 43:21 Md. R. 1172—1180 (October 14, 2016), has been adopted with the nonsubstantive changes shown below.

Effective Date: January 2, 2017.

Attorney General's Certification

In accordance with State Government Article, §10-113, Annotated Code of Maryland, the Attorney General certifies that the following changes do not differ substantively from the proposed text. The nature of the changes and the basis for this conclusion are as follows:

COMAR 21.02.03.02 and 21.06.07.10: Minor typographical errors and corrections to comply with statutes.

Subtitle 02 STATE PROCUREMENT ORGANIZATION

21.02.03 Department of Budget and Management

Authority: State Finance and Procurement Article, §§3-405, 3-502, 12-101, 12-107, 13-103, 13-104, 13-107.1, and 13-111, Annotated Code of Maryland

.02 Review and Approval of Solicitations and Contracts for Services.

A. — B. (proposed text unchanged)

C. Policies and Procedures—Service Contracts **[[**and Information Technology Contracts**]]**.

(1) — (8) (proposed text unchanged)

D. (proposed text unchanged)

Subtitle 06 CONTRACT FORMATION AND AWARD

21.06.07 Bid and Contract Security/Bonds

Authority: State Finance and Procurement Article, §§12-101, 13-207—13-209, 13-216, and 17-102—17-109, Annotated Code of Maryland

.10 Performance and Payment Bonds.

A. Performance Bonds

(1) General. A performance bond is required for all construction contracts in excess of $100,000 in the amount equal to at least 100 percent of the contract price. *A performance bond may be required for a* **[[***contact***]]** *contract for services, supplies, maintenance, or construction-related services expected to exceed* **[[***$50,000***]]** *$100,000, as determined by the procurement officer.* The performance bond shall be delivered by the contractor to the State not later than the time the contract is executed. If a contractor fails to deliver the required performance bond, the contractor's bid shall be

rejected, its bid security shall be enforced, and award of the contract may be made to the next lowest responsive and responsible bidder.

(2) (proposed text unchanged)

B. — C. (proposed text unchanged)

SHEILA McDONALD
Executive Secretary

Title 36
MARYLAND STATE LOTTERY AND GAMING CONTROL AGENCY

Subtitle 03 GAMING PROVISIONS

36.03.10 Video Lottery Facility Minimum Internal Control Standards

Authority: State Government Article, §§9-1A-02 and 9-1A-04, Annotated Code of Maryland

Notice of Final Action

[16-278-F]

On December 14, 2016, the Maryland State Lottery and Gaming Control Agency adopted amendments to Regulation **.11** under **COMAR 36.03.10 Video Lottery Facility Minimum Internal Control Standards**. This action, which was proposed for adoption in 43:22 Md. R. 1255 (October 28, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

GORDON MEDENICA
Director

Subtitle 07 INSTANT BINGO MACHINES IN ANNE ARUNDEL AND CALVERT COUNTIES

36.07.01 General

Authority: Criminal Law Article, §§12-301.1 and 12-308; State Government Article, §9-110; Annotated Code of Maryland

Notice of Final Action

[16-263-F]

On November 29, 2016, the Maryland State Lottery and Gaming Control Agency adopted amendments to Regulation **.03** under **COMAR 36.07.01 General**. This action, which was proposed for adoption in 43:21 Md. R. 1180—1181 (October 14, 2016), has been adopted as proposed.

Effective Date: January 2, 2017.

GORDON MEDENICA
Director

Withdrawal of Regulations

Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 15 UNFAIR TRADE PRACTICES

Notice of Withdrawal

[16-012-W]

The Insurance Commissioner withdraws proposed amendments to Regulations **.01—.07** under **COMAR 31.15.04 Solicitation of Annuity and Deposit Fund Contracts**, and proposed new Regulations **.01—.09** under a new chapter, **COMAR 31.15.15 Annuity Disclosure**, as published in 43:1 Md. R. 76—83 (January 8, 2016)

ALFRED W. REDMER, Jr.
Insurance Commissioner

Proposed Action on Regulations

For information concerning citizen participation in the regulation-making process, see inside front cover.

Symbol Key

- Roman type indicates existing text of regulation.
- *Italic type* indicates proposed new text.
- [Single brackets] indicate text proposed for deletion.

Promulgation of Regulations

An agency wishing to adopt, amend, or repeal regulations must first publish in the Maryland Register a notice of proposed action, a statement of purpose, a comparison to federal standards, an estimate of economic impact, an economic impact on small businesses, a notice giving the public an opportunity to comment on the proposal, and the text of the proposed regulations. The opportunity for public comment must be held open for at least 30 days after the proposal is published in the Maryland Register.

Following publication of the proposal in the Maryland Register, 45 days must pass before the agency may take final action on the proposal. When final action is taken, the agency must publish a notice in the Maryland Register. Final action takes effect 10 days after the notice is published, unless the agency specifies a later date. An agency may make changes in the text of a proposal. If the changes are not substantive, these changes are included in the notice of final action and published in the Maryland Register. If the changes are substantive, the agency must repropose the regulations, showing the changes that were made to the originally proposed text.

Proposed action on regulations may be withdrawn by the proposing agency any time before final action is taken. When an agency proposes action on regulations, but does not take final action within 1 year, the proposal is automatically withdrawn by operation of law, and a notice of withdrawal is published in the Maryland Register.

Title 07
DEPARTMENT OF HUMAN RESOURCES

Subtitle 02 SOCIAL SERVICES ADMINISTRATION

07.02.10 Youth Transitional Services

Authority: Courts and Judicial Proceedings Article, §3-801 et seq.; Family Law Article, §§1-101, 5-501—5-503, 5-524—5-525, 5-527—5-528, and 5-531—5-532; Annotated Code of Maryland
Agency Note: Federal Reference: Fostering Connection Act of 2008, PL110-35

Notice of Proposed Action

[16-351-P]

The Secretary of Human Resources proposes to amend Regulations **.01**, **.02**, **.04**, and **.09** under **COMAR 07.02.10 Youth Transitional Services**.

Statement of Purpose

The purpose of this action is to define "successful adulthood" to conform to the provisions of the federal "Preventing Sex Trafficking and Strengthening Families Act" (PL 113-183).

Comparison to Federal Standards

There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.

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 Tristan Fernandez, Government Affairs Administrator, Department of Human Resources, 311 W. Saratoga St. Baltimore, MD 21201, or call 410-767-8966, or email to Tristan Fernandez, or fax to 410-333-0637. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

.01 Purpose.

The purpose of Youth Transitional Services is to prepare and assist youth to make the transition to **[**independent living**]** *successful adulthood***.** Services are designed to promote self-sufficiency and responsible living.

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1)—(20) (text unchanged)

(21) "Successful adulthood" means when a youth exits the foster care system with the transitional skills to become self-sufficient as age and developmentally appropriate for the individual youth.

[(21)**]** *(22)*— **[**(22)**]** *(23)* (text unchanged)

.04 Program Requirements.

A. (text unchanged)

B. The local department shall promote youth participation in youth transitional services in order to encourage youth to accept responsibility for:

(1) (text unchanged)

(2) Making the transition from adolescence to *successful* adulthood.

.09 Transitional Youth Services.

A.—C. (text unchanged)

D. To **[**assure**]** *ensure* that youth participating in youth transitional services are provided personal and emotional support as they make the transition to *successful* adulthood, referrals shall be made to appropriate mentoring partners to foster positive mentoring relationships between youth and dedicated adults.

GREGORY S. JAMES
Acting Secretary of Human Resources

Title 08
DEPARTMENT OF NATURAL RESOURCES

Subtitle 02 FISHERIES SERVICE

08.02.21 Yellow Perch

Authority: Natural Resources Article, §§4-215 and 4-215.2, Annotated Code of Maryland

Notice of Proposed Action

[16-344-P]

The Secretary of Natural Resources proposes to amend Regulation **.03** under **COMAR 08.02.21 Yellow Perch**.

Statement of Purpose

The purpose of this action is to change the size limits for commercial hook and line to be consistent with other commercial harvest methods. Currently, the commercial yellow perch hook and line fishery operates under the same size and daily creel limits as the recreational hook and line yellow perch fishery (9-inch minimum size limit and a 10-fish daily creel limit). The action removes the current size limit for commercial hook and line and makes the 8 ½-inch minimum size limit and 11-inch maximum size limit currently in place for other commercial gear types apply to all commercial harvest. The 10-fish-per-day limit for hook and line is not changed. This change was requested by commercial fishermen. The change does not have a biological effect on the population and it standardizes all size limits among the commercial fishery.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The action may have an economic impact on individuals who harvest yellow perch commercially using hook and line.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:		
Size limit	(+)	Indeterminable
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

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

D. This action may have an impact on harvesters who use hook and line to catch yellow perch. The impact is indeterminable, but likely minimal. There are approximately 60 harvesters that declare that they will harvest yellow perch, about half of those actually harvest and less than 5 report harvesting with hook and line. No one reported harvest with hook and line in 2015 or 2016. This change may allow those harvesters to be more competitive in the yellow perch market and have some flexibility with their businesses, but the extent is unknown.

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 Yellow Perch Regulations, Regulatory Staff, Department of Natural Resources Fishing and Boating Services, 580 Taylor Avenue, B-2, Annapolis, MD 21401, or call 410-260-8300, or email to fisheriespubliccomment.dnr@maryland.gov, or fax to 410-260-8310. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

.03 Commercial.

A. (text unchanged)

B. Size.

[(1) The minimum size for yellow perch harvested by hook and line is 9 inches total length.**]**

[(2)**]** *(1)* The minimum size for yellow perch **[**harvested by means other than hook and line**]** is 8-1/2 inches total length.

[(3)**]** *(2)* The maximum size for yellow perch **[**harvested by means other than hook and line**]** is 11 inches total length.

C.—K. (text unchanged)

MARK J. BELTON
Secretary of Natural Resources

Title 09
DEPARTMENT OF LABOR, LICENSING, AND REGULATION

Subtitle 12 DIVISION OF LABOR AND INDUSTRY

09.12.43 Maryland Apprenticeship and Training

Authority: Labor and Employment Article, §11-405, Annotated Code of Maryland

Notice of Proposed Action

[16-340-P]

The Maryland Apprenticeship and Training Council proposes to amend Regulations **.02** and **.05** under **COMAR 09.12.43 Maryland Apprenticeship and Training**. This action was considered by the Council at a public meeting held on March 8, 2016, notice of which was published in 43:4 Md. R. 352 (February 19, 2016).

Statement of Purpose

The purpose of this action is to amend the regulations to allow for competency-based apprenticeship programs. This regulatory change

is necessary in order to come into conformity with United States Department of Labor federal standards of apprenticeship.

Comparison to Federal Standards

There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.

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 Christopher MacLarion, Director, Apprenticeship and Training, Dept. of Labor, Licensing and Regulation, 1100 N. Eutaw Street, Room 209, Baltimore, MD 21201, or call 410-767-3969, or email to christopher.maclarion@maryland.gov, or fax to 410-333-5162. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) — (4) (text unchanged)

(5) "Competency" means the attainment of manual, mechanical, or technical skills and knowledge as specified by an occupational standard and demonstrated by an appropriate written and hands-on proficiency measurement.

(6) Competency-Based Approach.

(a) "Competency-based approach" means a method to measure skill acquisition through the individual apprentice's successful demonstration of acquired skills and knowledge, as verified by the program sponsor.

(b) "Competency-based approach" includes requiring an apprentice to complete an on-the-job learning component of registered apprenticeship with the program standards addressing:

(i) How on-the-job learning will be integrated into the program;

(ii) Describing competencies; and

(iii) Identifying an appropriate means of testing and evaluation for such competencies.

[(5)**]** *(7)* — **[**(7)**]** *(9)* (text unchanged)

(10) "Hybrid approach" means a method to measure an individual apprentice's skill acquisition through a combination of a specified minimum number of hours of on-the-job learning and the successful demonstration of competency as described in a work process schedule.

[(8)**]** *(11)* — **[**(17)**]** *(20)* (text unchanged)

(21) "Time-based approach" means a method that measures skill acquisition through the individual apprentice's completion of at least 2,000 hours of on-the-job learning as described in a work process schedule.

.05 Standards of an Apprenticeship Program.

A. — C. (text unchanged)

D. An apprenticeship program shall include the following provisions:

(1) The employment and training of the apprentice in a skilled **[**trade**]** *occupation*;

(2) A term of apprenticeship, **[**of not less than 2,000 hours, consistent with the training requirements established by industry practice;**]** *which for an individual apprentice:*

(a) May be measured through either a time-based approach, a competency-based approach, or a hybrid approach; and

(b) Is determined by the program sponsor, subject to approval by the Division, with the advice of the Council, depending on which approach is appropriate for the apprenticeable occupation for which the program standards are registered;

(3) A work processes outline which:

(a) (text unchanged)

(b) Is an organized syllabus of operations and manual manipulative practices which shall be arranged in a logical manner and assigned sufficient time frames for these practices to equip an apprentice **[**or trainee**]** with a comprehensive basic skill development background to qualify for journeyperson or another stated training objective;

(4) — (22) (text unchanged)

E. — L. (text unchanged)

JAMES E. RZEPKOWSKI
Assistant Secretary for Workforce
Development and Adult Learning

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Notice of Proposed Action

[16-359-P-I]

The Secretary of Health and Mental Hygiene proposes to amend:

(1) Regulation **.04** under **COMAR 10.02.01 Charges for Services Provided Through the Department of Health and Mental Hygiene**;

(2) Regulation **.07** under **COMAR 10.09.02 Physicians' Services**;

(3) Regulations **.07** and **.10** under **COMAR 10.09.08 Freestanding Clinics**;

(4) Regulation **.07** under **COMAR 10.09.09 Medical Laboratories**;

(5) Regulation **.07** under **COMAR 10.09.15 Podiatry Services**;

(6) Regulation **.06** under **COMAR 10.09.38 Healthy Start Program**;

(7) Regulation **.11** under **COMAR 10.09.49 Telehealth Services**;

(8) Regulation **.07** under **COMAR 10.09.50 EPSDT School Health-Related Services or Health-Related Early Intervention Services**;

(9) Regulation **.20** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**;

(10) Regulation **.07** under **COMAR 10.09.87 Free-Standing Independent Diagnostic Testing Facilities**;

(11) Regulation **.07** under **COMAR 10.09.88 Portable X-ray Providers**;

(12) Regulation **.14** under **COMAR 10.11.03 Children's Medical Services Program**; and

(13) Regulation **.07** under **COMAR 10.48.01 Services**.

Statement of Purpose

The purpose of this action is to replace in its entirety the Medical Assistance Provider Fee Manual and incorporate by reference the

Professional Services Provider Manual and Fee Schedule. This proposal also updates references to this document in other chapters.

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 A. Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. 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 January 23, 2017. A public hearing has not been scheduled.

Editor's Note on Incorporation by Reference

Pursuant to State Government Article, §7-207, Annotated Code of Maryland, the Maryland Medical Assistance Program, Professional Services Provider Manual and Fee Schedule, Effective October 2016, has been declared a document generally available to the public and appropriate for incorporation by reference. For this reason, it will not be printed in the Maryland Register or the Code of Maryland Regulations (COMAR). Copies of this document are filed in special public depositories located throughout the State. A list of these depositories was published in 43:1 Md. R. 10 (January 8, 2016), and is available online at www.dsd.state.md.us. The document may also be inspected at the office of the Division of State Documents, 16 Francis Street, Annapolis, Maryland 21401.

Subtitle 02 DIVISION OF REIMBURSEMENTS

10.02.01 Charges for Services Provided Through the Department of Health and Mental Hygiene

Authority: Health-General Article, §§16-201—16-407, Annotated Code of Maryland

.04 Setting of Charges for Local Health Departments.

A. (text unchanged)

B. CPT-Based Charge.

(1) (text unchanged)

(2) Approved Method for Determining CPT-Based Charges.

(a) (text unchanged)

(b) For any health service performed by a local health department for which a rate is not assigned in the applicable Medicare Physicians Fee Schedule, the CPT-based charge shall be equivalent to 150 percent of the Maryland Medical Assistance participating provider fee allowance for the corresponding CPT code in the **[**current Maryland Medical Assistance Program, Physicians' Services Provider Fee Manual**]** *Professional Services Provider Manual and Fee Schedule*, as published by the Department and incorporated by reference in COMAR **[**10.09.02.07**]** *10.09.02.07D*.

(c) For any health service performed by a local health department for which a rate is not assigned on the applicable Medicare Physicians Fee Schedule or in the **[**current Maryland Medical Assistance Program, Physicians' Services Provider Fee Manual**]** *Professional Services Provider Manual and Fee Schedule*, the CPT-based charge shall be equivalent to the average hourly rate of the employees providing the service to the recipients of services,, calculated based upon current fiscal year salaries and fringe benefits, multiplied by the projected time of service with recipient of services, plus 20 percent for indirect costs.

C.—D. (text unchanged)

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.02 Physicians' Services

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

.07 Payment Procedures.

A.—C. (text unchanged)

D. The Maryland Medical Assistance **[**Program Physicians' Services Provider Fee Manual, Revision January 2014, is**]** *Program's procedures for payment are* contained in the **[**Medical Assistance Provider Fee Manual, dated October 1986**]** *Professional Services Provider Manual and Fee Schedule (Effective October 2016)*. All the provisions of this document, unless specifically excepted, are incorporated by reference.

E.—Q. (text unchanged)

10.09.08 Freestanding Clinics

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

.07 Freestanding Clinic Reimbursement Methodology.

A. Reimbursement for Family Planning Clinics. The Department shall pay the family planning clinic the lesser of the provider's customary charge or the provider's acquisition cost, but no more than the maximum reimbursement allowed for similar procedures or services required in **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D*. If the service is free to individuals not covered by Medicaid:

(1) The provider:

(a) (text unchanged)

(b) Shall be reimbursed in accordance with **[**the Provider Fee Manual**]** *COMAR 10.09.02.07D*; and

(2) (text unchanged)

B. Reimbursement for Abortion Clinics. For dates of service on or after April 1, 2015, the Department shall pay the abortion clinic the lesser of the provider's customary charge, but no more than the maximum reimbursement allowed for similar procedures or services required in **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D*. If the service is free to individuals not covered by Medicaid:

(1) The provider:

(a) (text unchanged)

(b) Shall be reimbursed in accordance with **[**the Provider Fee Manual**]** *COMAR 10.09.02.07D*; and

(2) (text unchanged)

C. (text unchanged)

D. The Department shall pay all other freestanding clinics at the lesser of the provider's customary charge, or the provider's acquisition cost, but no more than the maximum reimbursement allowed for similar procedures or services required in **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.02.07**]**

COMAR 10.09.02.07D. If the service is free to individuals not covered by Medicaid:

(1) The provider:

(a) (text unchanged)

(b) Shall be reimbursed in accordance with **[**the Provider Fee Manual**]** *COMAR 10.09.02.07D*; and

(2) (text unchanged)

.10 Payment Procedures.

A.—B. (text unchanged)

C. The provider shall bill the Program the provider's customary charge to the general public for similar services. If the service is free to individuals not covered by Medicaid:

(1) The provider:

(a) (text unchanged)

(b) Shall be reimbursed in accordance with **[**the Provider Fee Manual**]** *COMAR 10.09.02.07D*; and

(2) (text unchanged)

D.—I. (text unchanged)

10.09.09 Medical Laboratories

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

.07 Payment Procedures.

A.—C. (text unchanged)

D. **[**The fee schedule is contained in the Medical Assistance Provider Fee Manual, dated October 1, 1986, which is used in conjunction with "Physician's Current Procedural Terminology", and the Health Care Financing Administration's Common Procedure Code System (HCPCS). All the provisions of these documents, unless specifically noted, are incorporated by reference in this section, with the Medical Laboratories 2011 Provider Manual and Fee Schedule.**]** *Providers are reimbursed according to COMAR 10.09.02.07D*.

E.—P. (text unchanged)

10.09.15 Podiatry Services

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

.07 Payment Procedures.

A.—C. (text unchanged)

D. The Program shall pay for medically necessary covered services at the lower of the provider's amount billed to the Program or the maximum reimbursement rates set forth **[**on the physicians' fee schedule according to COMAR 10.09.02.07**]** *in COMAR 10.09.02.07D*.

E.—J. (text unchanged)

10.09.38 Healthy Start Program

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

.06 Payment Procedures.

A.—B. (text unchanged)

C. Payments shall be made:

(1)—(3) (text unchanged)

(4) For high-risk nutrition counseling as follows:

(a)—(c) (text unchanged)

(d) To all other eligible providers, according to **[**the current fee-for-service schedule specified in the Program Physicians' Provider Fee Manual which is contained in the Medical Assistance Provider Fee Manual, dated October 1986, all the provisions of which, unless specifically excepted, are incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D*.

10.09.49 Telehealth Services

Authority: Health-General Article, §§2-104(b) and 15-105.2(b), Annotated Code of Maryland; Ch. 280, Acts of 2013

.11 Reimbursement.

A.—B. (text unchanged)

C. Originating Site Transmission Fee.

(1) The telehealth transmission fee is set:

(a) In **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D*; or

(b) (text unchanged)

(2) (text unchanged)

D. Distant Site Professional Fee.

(1) The distant site professional fee shall be:

(a) For somatic services provided via telehealth, as set forth in **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D*; or

(b) For behavioral health services provided via telehealth, as set forth in **[**the Departmental fee schedule for Public Mental Health System Reimbursement, which is incorporated by reference in**]** COMAR 10.09.59.09.

(2) (text unchanged)

10.09.50 EPSDT School Health-Related Services or Health-Related Early Intervention Services

Authority: Health-General Article, §§2-104(b), 15-103, and 15-124, Annotated Code of Maryland

.07 Payment Procedures.

A.—D. (text unchanged)

E. Reimbursement for health-related services and health-related early intervention services is contained in **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, Revision January 2014, contained in the Medical Assistance Provider Fee Manual, dated October 1986, the provisions of which, unless specifically excepted, are incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D*. The State portion of reimbursement is provided by the Maryland State Department of Education.

10.09.67 Maryland Medicaid Managed Care Program: Benefits

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

.20 Benefits — EPSDT Services.

A. (text unchanged)

B. The health care services described in §A(3) of this regulation shall include, at a minimum, all services described in this chapter, and the following:

(1)—(2) (text unchanged)

(3) Audiology services, as listed in the Maryland Medical Assistance Audiology Procedure Code and Fee Schedule**[**: contained in the Medical Assistance Provider Fee Manual, all the provisions of which, unless specifically excepted are incorporated by reference in**]**, *according to* COMAR 10.09.51.04A(4);

(4)—(6) (text unchanged)

C. (text unchanged)

10.09.87 Free-Standing Independent Diagnostic Testing Facilities

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

.07 Payment Procedures.

A.—C. (text unchanged)

D. The Department's fee-schedule is contained in **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual which is incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D.*

E.—I. (text unchanged)

10.09.88 Portable X-ray Providers

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

.07 Payment Procedures.

A.—C. (text unchanged)

D. The Department's fee-schedule is contained in **[**the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual which is incorporated by reference in COMAR 10.09.02.07**]** *COMAR 10.09.02.07D.*

E.—I. (text unchanged)

Subtitle 11 MATERNAL AND CHILD HEALTH

10.11.03 Children's Medical Services Program

Authority: Health-General Article, §15-125, Annotated Code of Maryland

.14 Billing Procedures for Physician Office Services.

A. (text unchanged)

B. The CMS Program shall:

(1) Use the fee schedule contained in the *Maryland* Medical Assistance **[**Provider Fee Manual**]** *Program's Professional Services Provider Manual and Fee Schedule*, which is incorporated by reference in COMAR **[**10.09.02.07 and 10.09.09.07**]** *10.09.02.07D*;

(2) (text unchanged)

(3) Reimburse the provider for:

(a) (text unchanged)

(b) Injectable drugs at rates promulgated by the **[**Medical Assistance fee schedule for physician services**]** *Professional Services Provider Manual and Fee Schedule* referenced in §B(1) of this regulation.

C. (text unchanged)

Subtitle 48 CHILD ABUSE AND NEGLECT MEDICAL REIMBURSEMENT PROGRAM

10.48.01 Services

Authority: Family Law Article, §§5-701—5-910, Annotated Code of Maryland

.07 Payment Procedures.

A.—C. (text unchanged)

D. The fee schedule for covered services except hospital services shall be the same as is contained in the **[**July 1, 1982, Medical Assistance Provider Fee Manual, as amended, the provisions of**]** *Maryland Medical Assistance Program's Professional Services Provider Manual and Fee Schedule* which **[**are**]** *is* incorporated by reference **[**under**]** *in* COMAR **[**10.09.02, 10.09.03, and 10.09.09**]** *10.09.02.07D.*

E.—L. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 05 FREESTANDING AMBULATORY CARE FACILITIES

10.05.01 General Requirements

Authority: Health-General Article, §19-3B-03, Annotated Code of Maryland

Notice of Proposed Action

[16-353-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.08** under **COMAR 10.05.01 General Requirements**.

Statement of Purpose

The purpose of this action is to remove the outdated term "supervising physician" and replace it with "qualified health care practitioner". The change in this proposal was identified as a result of a comprehensive and extensive review of COMAR 10.05.01 conducted by the Office of Health Care Quality (OHCQ) which included inviting comments from stakeholders, OHCQ surveyors, and other departments; posting a notification on OHCQ's website; and sending out email notifications to approximately 300 stakeholders.

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 A. Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. 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 January 23, 2017. A public hearing has not been scheduled.

.08 Quality Assurance Program.

A.—B. (text unchanged)

C. Peer Review. The administrator shall ensure that the facility establishes a peer review process that includes:

(1) (text unchanged)

(2) Procedures, approved by a **[**supervising physician,**]** *qualified health care practitioner* to identify and minimize risks to the patient; and

(3) (text unchanged)

D.—G. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 05 FREESTANDING AMBULATORY CARE FACILITIES

10.05.03 Freestanding Major Medical Equipment Facilities

Authority: Health-General Article, §19-3B-07, Annotated Code of Maryland

Notice of Proposed Action

[16-336-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.04** under **COMAR 10.05.03 Freestanding Major Medical Equipment Facilities**.

Statement of Purpose

The purpose of this action is to remove the requirement for the Office of Health Care Quality to notify the licensee 5 days before conducting an on-site inspection thus allowing the Department to conduct on-site random sample survey reviews.

This was the only change identified as a result of a comprehensive and extensive review of COMAR 10.05.03 conducted by the Office of Health Care Quality (OHCQ) which included inviting comments from stakeholders, OHCQ surveyors, and other departments; posting a notification on OHCQ's website; and sending out email notifications to approximately 300 stakeholders.

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 A. Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. 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 January 23, 2017. A public hearing has not been scheduled.

.04 Inspections by the Secretary.

A. The Secretary may verify compliance with licensing requirements through on-site random sample record reviews. **[**Unless there is an immediate threat to the health and safety of patients or employees, the Secretary shall notify the licensee 5 days before conducting an on-site inspection.**]**

B. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Notice of Proposed Action

[16-346-P]

The Secretary of Health and Mental Hygiene proposes to:

(1) Amend Regulations **.01**, **.02**, **.17**, and **.18** under **COMAR 10.06.01 Communicable Diseases and Related Conditions of Public Health Importance**; and

(2) Repeal in their entirety Regulations **.01—.03** under **COMAR 10.18.04 Disease Control**.

Statement of Purpose

The purpose of this action is to:

(1) Repeal the chapter on HIV/AIDS control in Subtitle 18 (COMAR 10.18.04);

(2) Add HIV/AIDS control content to COMAR 10.06.01.17 which currently addresses syphilis control;

(3) Update wording to use "individual" rather than "person" when referring to a human being and not an entity that could be a human being or a corporation and to use the phrase "sexually transmitted infection" rather than "sexually transmitted disease";

(4) Update the time frame in which a physician shall report to the health officer an individual receiving treatment for or under medical observation for syphilis in an infectious stage from "immediately" to "within 1 working day" to maintain consistency with the information in the table found in COMAR 10.06.01.03;

(5) Add email addresses to the list of information that a physician shall endeavor to ascertain about those whom a patient with syphilis or HIV has potentially had infectious contact with;

(6) Remove language detailing isolation of the reported person as an action to be taken to protect the public health against a person not examined by a physician for infection with HIV/AIDS or syphilis within one week after notification of their exposure to the disease; and

(7) Remove "by a licensed physician" from the text stating that that a reported individual shall be examined to ascertain whether they have been infected with syphilis and HIV/AIDS.

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 January 23, 2017. A public hearing has not been scheduled.

Subtitle 06 DISEASES

10.06.01 Communicable Diseases and Related Conditions of Public Health Importance

Authority: Health-General Article, §§2-104(b), 18-102, *18-103*, 18-105, 18-201, *18.201.1*, 18-202, 18-205, *18-208*, 18-214.1, 18-307, *18-337*, and 24-101—24-110, Annotated Code of Maryland

.01 Scope.

A. This chapter does not apply to human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS) *surveillance, reporting, record maintenance, or confidentiality*, which **[**is**]** *are* covered by COMAR **[**10.18**]** *10.18.02 and 10.18.03*.

B. This chapter applies to human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS) control.

[B.**]** *C.* This chapter provides regulations for **[**cooperative**]** *coordinated control efforts for* communicable **[**disease**]** *diseases* and

related **[**condition control**]** *conditions* by the Department, local health officers, medical laboratory directors, physicians, veterinarians, and other Maryland governmental agencies, as guided by policy statements such as:

(1)—(2) (text unchanged)

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) "Case" means an individual who has laboratory or clinical evidence of being infected by an infectious agent.

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

[(3) "Case" or "case of a disease" means an individual who has laboratory or clinical evidence of being infected by an infectious agent. A case may or may not have symptoms of the infection.**]**

(4)—(25) (text unchanged)

(26) "Sexually transmitted **[**disease or**]** infection" means an infection which may be spread by sexual intercourse **[**or other forms of sexual contact with an infected individual, including a disease or condition classified as a venereal disease**]**, *including oral, anal, or vaginal sexual contact with an infected individual*.

(27)—(29) (text unchanged)

.17 [Sexually Transmitted Disease —] Syphilis *and HIV*.

A. Control of a Case.

(1) **[**A**]** *For an individual who appears to have or who has syphilis in a stage which is or may become communicable, or HIV, a* physician **[**in attendance upon an individual who appears to have, or who has, syphilis in a stage which is or may become communicable,**]** shall instruct the individual in the use of any measure**[**,**]** and render any treatment which may be necessary to prevent the spread of the disease.

(2) An individual under medical observation for diagnosis **[**or under treatment for**]** *of* syphilis *or HIV* shall remain under medical supervision until the:

(a) (text unchanged)

(b) Syphilis *or HIV*, if present, has been reported to the health officer; **[**and**]**

(c) **[**Person**]** *Individual with syphilis* has had the treatment that is necessary for the protection of the public health**[**.**]***; and*

(d) Individual with HIV has entered into HIV medical care.

(3) A physician **[**in attendance**]** shall report to the health officer **[**immediately**]** *within 1 working day* and in writing the name and address of an individual who is:

(a) (text unchanged)

(b) Under medical observation for diagnosis or treatment of syphilis in an infectious or potentially infectious stage, who fails to return for observation or treatment within 1 week of the date of a missed appointment, and is not known to the attending physician to be under medical observation or treatment elsewhere for this **[**disease**]** *infection.*

(4) A health officer shall:

(a) Investigate **[**a person**]** *an individual* reported to the health officer under the provisions of **[**§A(3)(b)**]** *§A(3)* of this regulation *or Health-General Article, §18-201.1, Annotated Code of Maryland,* who is within the health officer's territorial jurisdiction;

(b) Take such measures **[**, which may include isolation at home or in a hospital or other institution,**]** as may be deemed necessary for the protection of the public health; and

(c) Forward to the Secretary immediately a report of **[**a person**]** *an individual* reported under the provisions of **[**§A(3)(b)**]** *§A* of this regulation *or Health-General Article, §18-201.1, Annotated Code of Maryland,* who is outside the health officer's territorial jurisdiction for referral to the health officer of the proper jurisdiction.

B. Control of Contacts.

(1) A physician in attendance upon a patient having syphilis **[**shall**]** *or HIV*:

(a) **[**Endeavor**]** *Shall endeavor* to bring an individual with whom the patient has had potentially infectious contact to examination and **[**epidemiologic treatment**]**, *as appropriate, prophylaxis* by:

(i) Requesting the health officer to conduct a contact investigation of any case of syphilis**[**,**]** *or HIV;* or

(ii) Interviewing the patient in order to ascertain the names, descriptions, addresses, **[**and**]** telephone numbers, *and email addresses* of those with whom the patient has had potentially infectious contact; **[**and**]**

(b) **[**Report**]** *Shall report* immediately to the health officer **[**any untreated**]** *an* individual identified as having had potentially infectious contact with **[**an individual**]** *a patient* having syphilis *reported under the provisions of §A(3) of this regulation; and*

(c) May report to the health officer an individual identified as having had potentially infectious contact with a patient having HIV reported under Health-General Article, §18-201.1, Annotated Code of Maryland, if a patient that has been informed of the patient's HIV positive status refuses to notify the patient's sexual and needle-sharing partners.

(2) A health officer shall:

(a) Investigate and notify immediately an individual reported under the provisions of §B(1)(b) of this regulation, who is within the health officer's jurisdiction, **[**to submit to**]** *of the individual's exposure and advise the individual to undergo* a medical examination to ascertain whether the individual is infected with syphilis *or HIV*; *and*

(b) Forward immediately to the Secretary all reports of **[**persons**]** *individuals* who are outside the health officer's territorial jurisdiction for referral to the health officer of the proper jurisdiction**[**; and.

(c) Take action to protect the public health against a person who is not examined by a licensed physician for infection with this disease within 1 week after notification. This action may include isolation of the reported person at home or in a hospital or other institution**]**.

(3) A reported individual shall:

(a) Within 1 week of notification, be examined **[**by a licensed physician**]** to ascertain whether the individual has been infected with syphilis *or HIV*; and

(b) (text unchanged)

C.—D. (text unchanged)

.18 Other Sexually Transmitted [Diseases] *Infections*.

A. (text unchanged)

B. Control of Contacts.

(1) (text unchanged)

(2) A physician in attendance upon **[**a person**]** *an individual* who is a sexual contact of a case of a sexually transmitted **[**disease**]** *infection* shall perform a medical examination and render indicated treatment.

C. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 07 HOSPITALS

10.07.01 Acute General Hospitals and Special Hospitals

Authority: Health-General Article, §§19-308 and 19-308.6; Public Safety Article, §14-110.1; Annotated Code of Maryland

Notice of Proposed Action

[16-334-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.01** and adopt new Regulation **.31** under **COMAR 10.07.01 Acute General Hospitals and Special Hospitals**.

Statement of Purpose

The purpose of this action is to establish minimum regulatory standards that reflect a consensus on quality practices for palliative care programs within Maryland's hospitals. The standards are primarily based on recommendations generated from a report developed by the Maryland Health Care Commission in collaboration with the Office of Health Care Quality. This regulatory action is required by Health-General Article, §19–308.9, Annotated Code of Maryland.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. Through research and a pilot study, the Maryland Health Care Commission (MHCC) drafted a report providing cost estimates of implementing a palliative care program. The Office of Health Care Quality (OHCQ) utilized the 2015 MHCC report to determine the estimated cost for a large and a small hospital to implement a palliative care program. The report stated that 31 hospitals had such a program. OHCQ subtracted the number of hospitals the MHCC report identified as having a program from the total number of hospitals with 50 or more beds and determined that there were 10 hospitals remaining that would need to establish a palliative care program. These 10 hospitals were further broken down by the number of beds that are likely to need palliative care services. OHCQ estimates that a hospital with 60 or fewer beds would be able to meet the requirement by implementing a part-time palliative care program, while a hospital with 60 or more beds might require a full-time program. OHCQ estimates the costs to implement a palliative care program include utilizing the following staff: a physician, a nurse practitioner, and a social worker.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:		
Affected hospitals	(-)	$2,100,000
E. On other industries or trade groups:		
Physician, nurse practitioners, and social workers	(+)	$2,100,000
F. Direct and indirect effects on public:	NONE	

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

D. and E. The estimated implementation cost to hospitals has been determined by adding the following:

6 small hospitals × $150,000 cost for part-time palliative care program = $900,000

4 large hospitals × $300,000 cost for full-time palliative care program = $1,200,000

Estimated implementation cost:

Cost to small hospitals ($900,000) + Cost to large hospitals ($1,200,000) = $2,100,000

Trade group and industries will benefit as the implementation of 10 additional palliative care programs will provide additional employment opportunities.

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 January 23, 2017. A public hearing has not been scheduled.

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1)—(6) (text unchanged)

(7) "Authorized decision maker" means the health care agent, guardian of the person, or surrogate decision maker who is making health care decisions on behalf of a patient in accordance with the Health Care Decisions Act, Health-General Article, §§5-601—5-618, Annotated Code of Maryland.

[(6-1)**]** *(8)*—**[**(18)**]** *(21)* (text unchanged)

(22) "Medical Orders for Life Sustaining Treatment (MOLST) form" means the form required to be developed pursuant to Health-General Article, §5-608.1, Annotated Code of Maryland.

[(19)**]** *(23)* — **[**(21)**]** *(25)* (text unchanged)

(26) "Palliative care" means specialized medical care for individuals with serious illnesses or conditions that:

(a) Is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness or condition, whatever the diagnosis;

(b) Has the goal of improving quality of life for the patient, the patient's family, and other caregivers;

(c) Is provided at any age and at any stage in a serious illness or condition; and

(d) Can be provided along with curative treatment.

(27) "Palliative care program" means an interdisciplinary team that provides palliative care services.

[(22)**]** *(28)*—**[**(29)**]** *(37)* (text unchanged)

.31 Hospital Palliative Care Programs.

A. Acute general hospitals and special hospitals-chronic care with 50 or more beds shall establish an active hospitalwide palliative care program that provides consultation services to patients suffering from pain and symptoms due to serious illnesses or conditions.

B. The hospital shall:

(1) Promote the palliative care program;

(2) Provide information and referrals to patients and families when appropriate regarding the availability of palliative care services; and

(3) Inform patients of the patient's right to request a palliative care consultation.

C. Staffing.

(1) The hospital shall designate a qualified interdisciplinary care team with training in palliative care to staff the palliative care program.

(2) The hospital shall ensure that:

(a) A qualified health care professional coordinates the activities of the palliative care program with the palliative care patient's interdisciplinary care team;

(b) Staff is appropriately trained, credentialed, or certified in the staff's area of expertise;

(c) Staff receives continuing training and education; and

(d) Written policies and procedures for the hospital palliative care program are established, implemented, maintained, and updated periodically.

D. Palliative Care Education and Training. The hospital shall provide and document training to medical and other clinical staff as determined by the hospital regarding:

(1) Services provided by the palliative care program;

(2) Domains of palliative care; and

(3) Legal requirements for:

(a) Health care decisions; and

(b) MOLST as referenced in COMAR 10.01.21.

E. Interdisciplinary Plan of Care.

(1) The hospital shall incorporate the recommendations of the palliative care program into the palliative care patient's interdisciplinary care plan.

(2) The hospital shall review the interdisciplinary plan of care and revise it as necessary to meet the needs of the palliative care patient.

(3) The palliative care program shall conduct care conferences as appropriate to review the plan of care with:

(a) The palliative care patient;

(b) The palliative care patient's family;

(c) The health care professionals; and

(d) Other interdisciplinary team members.

(4) Contents. The hospital shall ensure that the palliative care patient's plan of care includes at a minimum:

(a) Initial assessments conducted by the interdisciplinary palliative care team;

(b) Psychological needs assessment;

(c) Treatment goals;

(d) Choice of treatment options;

(e) Preferred care setting;

(f) Preferred site of death and after-death arrangements, as appropriate;

(g) Grief and bereavement plan, as appropriate;

(h) Assessment of cultural needs;

(i) Assessment of legal needs; and

(j) Assessment of discharge needs.

(5) Collaboration. The hospital shall document and provide palliative care services in collaboration with:

(a) The attending physician; and

(b) Any other health care provider managing the patient's care.

(6) Continuity of Care. The hospital shall coordinate services to ensure continuity of care for the palliative care patient. The hospital shall:

(a) Transfer the pertinent parts of the medical record, medical orders, and plan of care with the palliative care patient upon transfer to post-acute care;

(b) Ensure that MOLST forms are completed in accordance with COMAR 10.01.21;

(c) Convert a palliative care patient's treatment goals into medical orders, as appropriate; and

(d) Have reporting mechanisms to keep all staff informed and updated about care changes and treatment goals.

F. Palliative Care Services.

(1) The hospital or palliative care program shall counsel the palliative care patient or the patient's authorized decision maker regarding:

(a) Health options;

(b) Pain management options;

(c) Prognosis;

(d) Risks and benefits of treatment;

(e) Availability of grief and bereavement services, as appropriate;

(f) Psychological services;

(g) Availability of spiritual care counseling through the hospital or outpatient providers; and

(h) Hospice services, as appropriate.

(2) Referrals.

(a) As appropriate and upon request by the patient or authorized decision maker, the hospital may make timely referrals.

(b) The hospital shall document any referrals made to:

(i) Inpatient or outpatient bereavement providers;

(ii) Psychological services for the palliative care patient and the patient's family;

(iii) Inpatient or outpatient spiritual care services; and

(iv) Hospice.

(3) Pain and Symptom Management. The hospital shall:

(a) Conduct and document pain and symptom assessments using available standardized scales to appropriately manage a palliative care patient's symptoms;

(b) Provide adequate and appropriate dosage of analgesics and sedatives to meet the needs of the palliative care patient; and

(c) Educate the patient and the patient's family about the use of opioids during end-of-life care.

(4) Other Services. The hospital shall provide culturally and linguistically appropriate education and support about how to safely care for the patient at home or in an alternate residential setting as appropriate.

(5) Imminent Death. The palliative care program shall document and counsel the patient, the authorized decision maker, the patient's family, and the interdisciplinary care team about the active dying phase and imminent death as appropriate.

(6) MOLST. The hospital shall comply with the procedures and requirements of the Medical Orders for Life-Sustaining Treatment Form, which is incorporated by reference at COMAR 10.07.21.

(7) Interpreter Services. The hospital shall ensure interpreter services are available and accessible to the palliative care program.

G. Advance Directives.

(1) The hospital shall recognize the authority of:

(a) An advance directive established in compliance with Health-General Article, §5-602, Annotated Code of Maryland; and

(b) An authorized decision maker.

(2) The hospital shall ensure that any provided advance directive and authorized decision maker designation are in the patient's medical record, including the electronic medical record.

(3) The hospital shall promote advance care planning and the completion of advance directives through community outreach activities.

H. Ethics Committee. The hospital shall allow staff, patients, and the patient's family in the palliative care program access to an ethics committee to address ethical conflicts at the end of life.

I. Quality Improvement. The palliative care program shall take part in the hospital's quality improvement and performance improvement activities to the extent required by State and federal statute.

J. Departmental Oversight. The Department shall have access to all data maintained through the hospital's palliative care program to determine the hospital's compliance with State and federal regulations.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[16-337-P]

The Secretary of Health and Mental Hygiene proposes to:

(1) Repeal in their entirety existing Regulations **.01—10** under existing **COMAR 10.09.01 Nurse Practitioner Services** and adopt new Regulations **.01—.08** under a new chapter, **COMAR 10.09.01 Advanced Practice Nurse Services**;

(2) Repeal in their entirety existing Regulations **.01—.11** under **COMAR 10.09.21 Nurse Midwife Services**; and

(3) Repeal in their entirety existing Regulations **.01—.10** under **COMAR 10.09.39 Nurse Anesthetist Services**.

Statement of Purpose

The purpose of this action is to adopt new streamlined regulations pertaining to advanced practice nurses under one chapter.

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 January 23, 2017. A public hearing has not been scheduled.

10.09.01 Advanced Practice Nurse Services

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

.01 Definitions.

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

B. Terms Defined.

(1) "Advanced practice nurse" means a:

(a) Certified nurse practitioner;

(b) Certified nurse midwife; or

(c) Certified registered nurse anesthetist.

(2) "American College of Nurse-Midwives (ACNM)" means the private professional organization which:

(a) Sets the standards nationwide for the education and practice of nurse midwives; and

(b) Certifies, by examination, those who have completed the approved educational program.

(3) "Board" means the Maryland State Board of Nursing.

(4) "Certified nurse midwife (CNM)" means a registered nurse who is:

(a) Certified by the Board to practice nurse midwifery; and

(b) Certified by the American College of Nurse-Midwives.

(5) "Certified nurse practitioner" means:

(a) A registered nurse who, by reason of certification under COMAR 10.27.07, may practice in Maryland as a nurse practitioner under the terms of that chapter; or

(b) If out-of-State, a registered nurse who qualifies as a nurse practitioner in the state in which services are provided.

(6) "Certified registered nurse anesthetist (CRNA)" means a registered nurse who is certified to practice nurse anesthesia by the Board.

(7) "Department" means the Department of Health and Mental Hygiene, as defined in COMAR 10.09.36.01.

(8) "Newborn" means an infant who is not more than 48 hours old.

(9) "Nurse midwifery" means the health care management of newborns and women throughout their reproductive life cycle.

(10) "Participant" means an individual who is certified as eligible for, and is receiving Medical Assistance benefits.

(11) "Physician" means an individual who meets the licensure requirements and conditions of participation of COMAR 10.09.02.

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

(13) "Provider" means an advanced practice nurse who, through appropriate agreement with the Department, has been identified as a Program provider by the issuance of a provider number.

.02 License and Certification Requirements.

A. The provider shall meet all license requirements as set forth in COMAR 10.09.36.02.

B. A certified nurse practitioner applying for provider status shall:

(1) Hold a current license to practice registered nursing in Maryland and be certified as a nurse practitioner by the Board; or

(2) Meet the nurse practitioner regulatory requirements of the state in which the services are provided.

C. A certified nurse midwife applying for provider status shall:

(1) Hold a current license to practice registered nursing in Maryland, be certified as a nurse midwife by the American College of Nurse-Midwives, and be in compliance with requirements to practice nurse midwifery established by the Board; or

(2) Meet the nurse midwife regulatory requirements of the state in which the services are provided.

D. A certified registered nurse anesthetist applying for provider status shall:

(1) Hold a current license to practice registered nursing in Maryland and meet the requirements of the Board as set forth in COMAR 10.27.06; or

(2) Meet the nurse anesthetist regulatory requirements of the state in which the services are provided.

.03 Conditions for Participation.

A. A provider shall meet all conditions for participation as set forth in COMAR 10.09.36.03.

B. An advanced practice nurse may not knowingly employ or contract with a person, partnership, or corporation which the

Program has disqualified from providing or supplying services to Program participants.

.04 Covered Services.

A. Subject to §B of this regulation, the Program covers medically necessary services rendered to participants as follows:

(1) For nurse practitioners:

(a) Medically necessary services within the provider's scope of practice as described in COMAR 10.27.07; or

(b) If out-of-State, nurse practitioners' services authorized in the state in which the services are provided;

(2) For nurse midwives:

(a) Medically necessary services within the provider's scope of practice as described in COMAR 10.27.05; or

(b) If out-of-State, nurse midwives' services authorized in the state in which the services are provided;

(3) For nurse anesthetists:

(a) Medically necessary services within the provider's scope of practice as described in COMAR 10.27.06; or

(b) If out-of-State, nurse anesthetists' services authorized in the state in which the services are provided;

(4) Laboratory services when the advanced practice nurse is not required to register their office as a medical laboratory pursuant to Health-General Article, Title 17, Subtitle 2, Annotated Code of Maryland; and

(5) Drugs and supplies within the nurse's scope of practice.

B. The services in §A of this regulation shall be:

(1) Clearly related to the participant's medical needs; and

(2) Described in the participant's medical record in sufficient detail to support the invoice submitted for those services.

.05 Limitations.

The Program does not cover the following under this chapter:

A. Services not medically necessary;

B. Services prohibited by the Maryland Nurse Practice Act or by the Board;

C. Advanced practice nursing services included as part of the cost of:

(1) An inpatient facility;

(2) A hospital outpatient department; or

(3) A freestanding clinic;

D. Visits by or to the provider solely for the purpose of the following:

(1) Prescription, drug, or food supplement pick-up;

(2) Recording of an electrocardiogram;

(3) Ascertaining the patient's weight;

(4) Interpretation of laboratory tests or panels; or

(5) Prescribing or administering medication;

E. Drugs and supplies which are acquired by the provider at no cost;

F. Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take oral medications are documented in the patient's medical record;

G. More than one visit per day unless adequately documented as an emergency situation;

H. Services paid under the free-standing dialysis program as described in COMAR 10.09.22;

I. Immunizations required for travel outside the continental United States;

J. Prescriptions and injections for central nervous system stimulants and anorectic agents when used for weight control;

K. Acupuncture;

L. Hypnosis;

M. Travel expenses;

N. Investigational or experimental drugs and procedures;

O. Services denied by Medicare as not medically justified;

P. Specimen collection, except by venipuncture and capillary or arterial puncture, as a separate service;

Q. Those laboratory or X-ray services performed by another facility, which shall be billed to the Program directly by the facility; and

R. For certified nurse midwives, a separate visit charge on date of delivery.

.06 Payment Procedures.

A. The provider shall submit the request for payment in the format designated by the Department.

B. The Department reserves the right to return to the provider, before payment, all requests for payment not properly completed.

C. The provider shall charge the Program the provider's:

(1) Customary charge to the general public for similar services; and

(2) Acquisition cost for injectable drugs or dispensed medical supplies.

D. The provider shall be paid the lesser of:

(1) The provider's customary charge to the general public unless the service is free to individuals not covered by Medicaid; or

(2) The Medicaid rates as described in COMAR 10.09.02.07.

E. If a service is free to individuals not covered by Medicaid:

(1) The provider:

(a) May charge the Program; and

(b) Shall be reimbursed in accordance with §D of this regulation; and

(2) The provider's reimbursement is not limited to the provider's customary charge.

F. Payments on Medicare claims are authorized, if:

(1) Services are covered by the Program;

(2) The provider accepts Medicare assignments;

(3) Medicare makes direct payment to the provider;

(4) Medicare has determined that services were medically justified; and

(5) Initial billing is made directly to Medicare according to Medicare guidelines.

G. The Department shall make supplemental payments on Medicare claims subject to the following provisions:

(1) Deductible insurance shall be paid in full; and

(2) Coinsurance shall be paid at the lesser of:

(a) 100 percent of the coinsurance amount; or

(b) The balance remaining after the Medicare payment is subtracted from the Medicaid rate.

H. The provider may not bill the Program for:

(1) Completion of forms and reports;

(2) Broken or missed appointments; or

(3) Professional services rendered by mail or telephone.

I. The Program may not make direct payment to recipients.

J. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.

K. The Program shall reimburse for all medical laboratory services according to the fees established under COMAR 10.09.09.

L. An advanced practice nurse who is employed by or under contract to any physician, clinic, or hospital may not bill for any service for which reimbursement is sought by the physician, clinic, or hospital.

M. The Program may not reimburse nurse midwives for prenatal or postpartum care once the patient has been referred to a physician for completion of prenatal or postpartum care.

.07 Recovery and Reimbursement.

Recovery and reimbursement are as set forth in COMAR 10.09.36.07.

.08 Causes for Suspension or Removal and Imposition of Sanctions.

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

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[16-332-P]

The Secretary of Health and Mental Hygiene proposes to:

(1) Repeal Regulations **.01—.18** under **COMAR 10.09.06 Hospital Services**;

(2) Adopt new Regulations **.01—.14** under a new chapter, **COMAR 10.09.92 Acute Hospitals**;

(3) Adopt new Regulations **.01—.16** under a new chapter, **COMAR 10.09.93 Chronic Hospitals**;

(4) Adopt new Regulations **.01—.13** under a new chapter, **COMAR 10.09.94 Special Pediatric Hospitals**; and

(5) Adopt new Regulations **.01—.13** under a new chapter, **COMAR 10.09.95 Special Psychiatric Hospitals**.

Statement of Purpose

The purpose of this action is to replace in its entirety the Hospital Services chapter and create separate chapters for Acute, Chronic, Special Pediatric and Special Psychiatric Hospitals, respectively.

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 January 23, 2017. A public hearing has not been scheduled.

10.09.92 Acute Hospitals

Authority: Health-General Article, §§2-104(b), 15-102.8, 15-103, and 15-105, Annotated Code of Maryland

.01 Definitions.

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

B. Terms Defined.

(1) "Acute hospital" means an institution that provides active, short-term medical diagnosis, treatment, and care.

(2) "Acute level of care" means care in which a patient is treated:

(a) For a brief but severe episode of illness, for conditions that are the result of disease or trauma; and

(b) During recovery from surgery.

(3) "Acute rehabilitation hospital" means an institution devoted to therapy that is designed to facilitate the process of recovery from illness or injury for patients with various neurological, muscular-skeletal, orthopedic, and other medical conditions following stabilization of acute medical issues.

(4) "Administrative day" means a day of medical services delivered to a participant who no longer requires an acute level of care.

(5) "Administrative services organization (ASO)" means an organization with which the Department contracts to assist in the management and operation of the Maryland Public Behavioral Health System.

(6) "Admission" means the formal acceptance by a hospital of a participant who is to be provided with room, board, and medically necessary services in an area of the hospital where patients stay at least overnight.

(7) "Ancillary services" means diagnostic and therapeutic services, including but not limited to radiology, laboratory tests, pharmacy, and physical therapy services, provided exclusive of room and board.

(8) "Concurrent review" means a periodic reauthorization of continued medical eligibility for the level of services provided in an acute hospital which allows for close monitoring of the participant's progress, treatment goals, and objectives during an inpatient hospitalization.

(9) "Date of service" means:

(a) For inpatient hospitalizations, the date of admission into an acute hospital up to, but not including, the date of discharge;

(b) For outpatient services, the date services are rendered in the outpatient department of the hospital;

(c) For emergency services, the date or dates the services are rendered in the emergency department of an acute hospital; or

(d) For observation services, the date or dates the services are rendered in an acute hospital.

(10) "Department" means the Maryland Department of Health and Mental Hygiene, which is the single State agency designated to administer the Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

(11) "Designee" means any entity designated to act on behalf of the Department.

(12) "Diagnosis-related group" means a participant classification system adopted by the U.S. Department of Health and Human Services, in which each hospital discharge case is assigned a category based on the primary diagnosis, secondary diagnoses (if any), procedures performed, age, sex, and discharge status of the participant.

(13) "Electronic signature" means a secure electronic identification of an individual who authorizes an electronic record or transaction.

(14) "Emergency department" means the area in a hospital that is designed, staffed, and equipped to provide prompt treatment to individuals requiring immediate medical care for acute illness, trauma, and other medical conditions.

(15) "Emergency services" means any health care service provided to evaluate and treat any medical condition where immediate, unscheduled medical care is required.

(16) "Emergent condition" means a disease, illness, or injury characterized by sudden onset and symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(a) Placing the participant's health or, with respect to a pregnant woman, the health of the woman or unborn child in serious jeopardy;

(b) Serious impairment of bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(17) "Freestanding medical facility" means a facility:

(a) In which medical and health services are provided;

(b) That is physically separate from a hospital or hospital grounds; and

(c) That is an administrative part of a hospital or related institution.

(18) "Health Services Cost Review Commission (HSCRC)" means the independent organization within the Department of Health and Mental Hygiene which is responsible for reviewing and approving rates for hospitals pursuant to Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland.

(19) "Maryland Medical Assistance Program" means the program of comprehensive medical and other health-related care for indigent and medically indigent individuals.

(20) "Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with standards of good medical practice;

(c) The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the participant, family, or provider.

(21) "Medicare" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

(22) "Nonqualified alien" means a foreign-born resident who:

(a) Is not a naturalized U.S. citizen; and

(b) Is eligible for federal Medical Assistance coverage of only emergency medical services, as specified under COMAR 10.09.24.05-2A.

(23) "Observation services" means the medically necessary services used to assess the participant's outpatient condition to determine the need for possible admission to an inpatient acute care setting.

(24) "Organ" means a part of an organism that is typically self-contained and has a specific vital function, such as a heart or liver.

(25) "Out-of-State hospital" means any hospital outside of Maryland, except for hospitals located in the District of Columbia.

(26) "Outpatient services" means nonemergency services provided to the participant on the hospital campus that do not require hospital admission.

(27) "Participant" means an individual who is enrolled with the Department to receive Medical Assistance services.

(28) "Patient" means an individual awaiting or undergoing health care or treatment.

(29) "Preauthorization" means the approval required from the Department or its designee before a service can be rendered by the provider and reimbursed.

(30) "Preoperative day" means an inpatient day in an acute hospital before:

(a) Surgery for a participant who is being admitted for surgery; or

(b) A surgical procedure when the participant was admitted for a nonsurgical procedure but the need for surgery arose during that stay.

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

(32) "Prospective payment system" means a predetermined amount of reimbursement per day for inpatient hospital services.

(33) "Provider" means an acute hospital which, through agreement with the Department, has been identified as a Program provider by the issuance of a provider number.

(34) "Retrospective review" means the process of determining medical necessity of an inpatient admission after the participant has been discharged from the hospital.

(35) "Specialty behavioral health" means services as defined in COMAR 10.09.70.02D and F.

.02 License Requirements.

A. In order to participate in the Program, a provider shall:

(1) Be licensed as a hospital by the Department pursuant to Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland; and

(2) Obtain other licenses, as set forth in COMAR 10.07.01.

B. The provider shall ensure that Clinical Laboratory Improvement Amendments (CLIA) certification exists for all clinical laboratory services performed, and:

(1) If located in Maryland, comply with requirements of:

(a) Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland; and

(b) COMAR 10.10.01; or

(2) If located out-of-State, comply with:

(a) All applicable standards established by the state or locality in which the service is provided; and

(b) The requirements of COMAR 10.09.09.02.

.03 Conditions for Participation.

A. A provider shall meet all conditions for participation as set forth in COMAR 10.09.36.03.

B. To participate in the Program as an acute hospital services provider, the provider shall:

(1) Meet the requirements of Title XIX of the Social Security Act for participation as a hospital, as issued by the Department of Health and Human Services;

(2) Directly provide or make available through contractual arrangements or transfer agreements, medically necessary covered services;

(3) Accept payment by the Program as payment in full for the covered service;

(4) Make available to the Department or its designee the participant's medical record for review and certification of medical necessity for admission and continuation of stay;

(5) Maintain documentation of each contact with the participant as part of the complete medical record, which, at a minimum, includes:

(a) Date of service;

(b) The participant's chief medical complaint or reason for visit;

(c) A description of the services provided, including:

(i) Progress notes;

(ii) Imaging studies;

(iii) Laboratory results;

(iv) Medication administration records; and

(v) Discharge summary; and

(d) A signature, electronic or handwritten, along with the printed or typed name of the individual providing care, with the appropriate title; and

(6) If the hospital provider is the only hospital within the county, participate with each participating HealthChoice Managed Care Organization in the county.

C. If an out-of-State or District of Columbia hospital, the hospital shall:

(1) Unless a waiver has been granted by the Secretary of Health and Human Services, have in effect a utilization review plan applicable to all participants who receive Medical Assistance under

Title XVII of the Social Security Act which meets the requirements of §1861(k) of the Social Security Act; and

(2) Comply with applicable regulations of this chapter and COMAR 10.09.36.

.04 Covered Services.

A. The Program covers the services listed in §B of this regulation according to the conditions and requirements indicated.

B. The Program covers the following hospital services:

(1) Medically necessary emergency services as defined in COMAR 10.09.36.01, including triage, related ancillary services, and when necessary, observation stays of a participant who presents to a hospital emergency department;

(2) Medically necessary services performed in an outpatient department of a hospital;

(3) Medically necessary services performed at a freestanding medical facility;

(4) Medically necessary inpatient hospital services meeting the following criteria:

(a) Inpatient days, including preoperative days, determined to be medically necessary by the Department or its designee;

(b) Admissions from an emergency department resulting in a medically necessary inpatient stay; and

(c) Elective admissions that the Department or its designee determines to be medically necessary;

(5) Inpatient stays determined to be medically necessary due to an emergent condition by the Department or its designee for a nonqualified alien;

(6) Administrative days determined to be necessary by the Department or its designee; and

(7) Medically necessary services performed in an acute rehabilitation hospital when the participant meets the following criteria at the time of admission:

(a) Requires active and ongoing therapeutic intervention of multiple therapy disciplines, one of which shall be physical or occupational therapy;

(b) Requires and can reasonably be expected to actively participate in, and benefit from, the therapy, which generally consists of:

(i) At least 3 hours of therapy a day, at least 5 days a week; or

(ii) In well-documented cases, at least 15 hours of intensive rehabilitation therapy within a 7 day consecutive period;

(c) Is sufficiently stable to be able to actively participate in the therapy program; and

(d) Requires supervision by a licensed physician, who has specialized training and experience in inpatient rehabilitation, which includes:

(i) Conducting face-to-face visits with the patient at least 3 days a week to assess the patient both medically and functionally; and

(ii) Modifying the course of treatment as needed to maximize the participant's capacity to benefit from the rehabilitation process.

.05 Limitations.

The Program does not cover:

A. Hospital services, procedures, drugs, or hospital admissions that are investigational or experimental;

B. Hospital services denied by Medicare as not medically necessary;

C. Inpatient admissions or outpatient visits solely for the administration of injections, unless medical necessity and the participant's inability to take appropriate oral medications is documented in the participant's medical record;

D. Elective inpatient admissions without preauthorization;

E. Elective inpatient admissions from the emergency department for dialysis services that are the result of problems occurring with placement in a freestanding dialysis facility;

F. Outpatient visits for one or more of the following:

(1) Prescription drug or food supplement pick up;

(2) Collection of specimens for laboratory procedures;

(3) Recording of an electrocardiogram;

(4) Ascertaining the participant's weight; and

(5) Administration of vaccines;

G. Interpretation of laboratory tests or panels;

H. Autopsies;

I. Weight control medications;

J. Care provided to a well newborn beyond the:

(1) Length of the mother's stay for a normal obstetrical or uncomplicated caesarean section delivery; or

(2) First 4 days of the newborn's life when the mother remains in the hospital due to other circumstances;

K. Telephones, televisions, or personal comfort items or services;

L. Duplicate care or services;

M. Elective admissions to hospitals outside of Maryland, except the District of Columbia, unless the Department or its designee determines that comparable services are not available in Maryland;

N. Inpatient and outpatient diagnostic and laboratory services not ordered by the attending physician or other practitioner;

O. Inpatient days provided in excess of the days approved by the Department or its designee;

P. Hospital laboratory tests which are coverable under COMAR 10.09.09, unless the specimen is obtained in the hospital for a participant receiving inpatient, outpatient, emergency department, or observation services; and

Q. Hospital services provided outside of the United States.

.06 Utilization Review.

A. Elective Inpatient Preauthorization Reviews.

(1) The hospital shall only request preauthorization for inpatient stays when such services:

(a) Cannot be provided on an outpatient basis; or

(b) Can only be provided in a facility that is licensed as an acute hospital.

(2) The hospital shall obtain preauthorization for elective inpatient admissions from the Department or its designee, before the participant is admitted, by providing the following information including, but not limited to:

(a) Participant's medical history and physical;

(b) Doctor's progress notes; and

(c) Sufficient clinical information or documentation that supports the medical necessity of the acute inpatient admission.

B. Concurrent Reviews.

(1) As long as the participant remains hospitalized, the Department or its designee shall perform concurrent reviews based on the participant's diagnosis and medical condition.

(2) For emergency inpatient admissions that exceed more than 24 hours, the concurrent review process shall be initiated by the hospital within the first 48 hours of the admission, or by the next business day.

(3) For elective inpatient admissions, the hospital shall initiate the concurrent review process before the termination of days previously certified by the Department or its designee.

(4) The hospital shall forward sufficient clinical documentation to the Department or its designee that supports the need for continuing acute care. Documentation submitted shall include, but is not limited to:

(a) Current medical health status;

(b) Treatment received to date; and

(c) A proposed treatment plan for the continued stay.

C. Retrospective Reviews.

(1) The hospital shall request that the Department or its designee perform a retrospective review of an inpatient admission after the participant is discharged, to determine the medical necessity of the admission and stay.

(2) The hospital shall provide the following to the Department or its designee when requesting a retrospective review following discharge from an acute hospital. Documentation submitted shall include, but is not limited to:

(a) The participant's complete medical record;

(b) The principal, secondary, and tertiary diagnoses; and

(c) All surgical procedure codes.

D. Reviews for Nonqualified Aliens. The Department or its designee reviews the admission and discharge summary of an emergency inpatient admission for a nonqualified alien to determine whether the inpatient hospital stay meets the emergent condition criteria as defined in COMAR 10.09.24.05-2A.

E. Reviews for Behavioral Health. The hospital shall contact the behavioral health ASO to request an authorization for all inpatient admissions that are described in COMAR 10.09.70.02D and F.

.07 Payment Procedures.

A. Reimbursement Principles for Acute Hospitals Located in Maryland.

(1) The Department will make no direct reimbursement to any State-operated hospital. The Department will claim federal fund recoveries from the U.S. Department of Health and Human Services for services to participants in State-operated hospitals.

(2) Acute hospitals located in Maryland that participate in the Program, shall charge the rates approved by the HSCRC and be reimbursed 94 percent pursuant to COMAR 10.37.10, except for administrative days.

(3) If the Program discontinues using rates which have been approved by HSCRC, the Program shall reimburse providers:

(a) According to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR §413; or

(b) On the basis of charges if less than reasonable cost.

(4) The Department may not reimburse for the services of a hospital's salaried or contractual physicians as a separate line item. Charges for these services should be included in the room and board rate or the appropriate ancillary service only, when HSCRC has included these salaries in the hospital's costs.

(5) The Program shall reimburse room and board charges from the day of admission up to, but not including, the date of discharge from the hospital.

(6) The provider shall submit a request for payment according to procedures established by the Department.

(7) The Program reserves the right to return to the provider any invoice that is not properly completed.

(8) Payments on Medicare claims are authorized if:

(a) The provider accepts Medicare assignment;

(b) Medicare makes a direct payment to the provider;

(c) Medicare determined that services are medically necessary;

(d) The services are covered by the Program; and

(e) Initial billing is made directly to Medicare according to Medicare guidelines.

(9) The Department shall make a supplemental payment on Medicare claims as follows:

(a) Deductible and co-insurance shall be paid in accordance with the limits of this regulation; and

(b) Hospitals shall be paid subject to the HSCRC discounts, except in the case of a participant receiving hospital services in an out-of-State facility, in which case the deductible and co-insurance shall be paid in full.

(10) The provider shall not bill the Department or participant for:

(a) Completion of forms and reports;

(b) Broken or missed appointments;

(c) Services rendered by mail, telephone, or otherwise not in person, with the exception of telehealth services in accordance with COMAR 10.09.49; and

(d) Providing a copy of a participant's medical record, when requested by another licensed provider on behalf of the participant.

(11) Billing time limitations are set forth in COMAR 10.09.36.06.

(12) Freestanding medical facilities are reimbursed by the Department at the rate set for the freestanding facility by HSCRC.

B. Reimbursement Principles for Out-of-State Hospitals.

(1) For hospitals outside of Maryland, excluding the District of Columbia, claims reflecting dates of service on or after October 1, 2009, shall be reimbursed at a rate that is 100 percent of the amount reimbursable by the host state's Title XIX agency or the amount of the hospital's actual charges in total, whichever is less.

(2) Out-of-State providers are responsible for reimbursing the Department or its designee for overpayments, in accordance with COMAR 10.09.36.07.

C. Reimbursement Principles for Administrative Days.

(1) The hospital shall be paid for administrative days that are requested at the time of retrospective review and that are authorized by the Department or its designee after review of the:

(a) Clinical documentation;

(b) Discharge plan indicating that the hospital was seeking placement for the participant on the administrative days requested; and

(c) Documentation that was submitted to the Department on the authorized form that shows placement activity occurred on each day claimed as an administrative day.

(2) To be paid for administrative days, for participants who are not ventilator dependent, the reimbursement amount shall be an estimated Statewide average of the Program nursing home payment rate as determined by the Department.

(3) A hospital is not eligible for administrative day reimbursement if the days have already been billed as acute days.

D. Reimbursement Principles for Freestanding Acute Rehabilitation Hospitals. For freestanding acute rehabilitation hospitals not approved by the Program for reimbursement according to HSCRC rates, the Department shall reimburse these hospitals using a prospective payment system.

.08 District of Columbia Hospital Reimbursement.

A. Inpatient Services Rate Calculation.

(1) A hospital in the District of Columbia shall:

(a) Bill its usual and customary charges; and

(b) Be reimbursed for covered services the lesser of its percentage of charges as calculated in §A(2) of this regulation or its charges.

(2) The percentage of charges in §A(1) of this regulation is the product of the following:

(a) The cost-to-charges percentage using only those costs of the hospital reported in the hospital's most recent cost report as determined by the Program or its designee;

(b) The lesser of 100 percent or the cost-to-charge projection percentage which is:

(i) The hospital's cost-to-charge ratio in its most recent cost report trended by its cost-to-charge ratio in the 2 prior years' cost reports or, if 3 years of data are not available, the hospital's cost-to-charge ratio in its most recent cost report divided by its cost-to-charge ratio in the prior year's cost report; and

(ii) Applied from the midpoint of the report period used to develop the cost-to-charges percentage in §A(2)(a) of this regulation, to the midpoint of the prospective payment period;

(c) The percentage of the hospital's costs which are efficiently and economically incurred as adjusted to reflect labor market differences between District of Columbia hospitals and Maryland hospitals; and

(d) The uncompensated care factor which is equal to:

(i) For pediatric hospitals with average lengths of stay less than 18 days, one plus two and a half times the quotient of the hospital's uncompensated care divided by gross revenue; or

(ii) For all other hospitals, one plus the quotient of the hospital's uncompensated care divided by gross revenue.

(3) Effective for dates of service starting July 1, 2012, and forward, the rate calculated for FY 2012 in accordance with §A(2) of this regulation shall be increased by 9 percent.

(4) A hospital in the District of Columbia shall be reimbursed for administrative days in accordance with Regulation .07C of this chapter.

(5) Efficiently and economically incurred District of Columbia hospitals' costs are those costs which are:

(a) Less than or equal to the adjusted costs for the same all-participant, refined-diagnosis-related groups in Maryland hospitals;

(b) For hospitals with average lengths of stay of 18 days or more:

(i) Less than or equal to the adjusted cost for the same diagnosis-related groups in Maryland hospitals; and

(ii) Categorized into the following two age groups: younger than 18 years old, and 18 years old or older;

(c) Exclusive of:

(i) Maryland case charges greater than $500,000; and

(ii) District of Columbia hospital case charges greater than $500,000 times the ratio of the average charge of the District of Columbia hospital case divided by the average charge of the Maryland hospital case; and

(d) Derived from hospital costs as specified in this subsection.

(6) Maryland hospital costs are the hospitals' charges reduced by the hospital-specific ratio of operating costs to gross charges as determined by the Program or designee.

(7) There may not be a year-end cost settlement.

B. Outpatient Services.

(1) A hospital located in the District of Columbia shall:

(a) Bill its usual and customary charges; and

(b) Be reimbursed for covered services the lesser of its percentage of charges as calculated in §B(2) of this regulation or its charges.

(2) The percentage of charges in §B(1) of this regulation is the product of:

(a) The cost-to-charges percentage using only those costs of the hospital reported in the hospital's most recent cost report as determined by the Program or its designee; and

(b) The lesser of 100 percent or the cost-to-charge projection percentage which is:

(i) The hospital's cost-to-charge ratio in its most recent cost report trended by its cost-to-charge ratio in the 2 prior years' cost reports or, if 3 years of data are not available, the hospital's cost-to-charge ratio in its most recent cost report divided by its cost-to-charge ratio in the prior year's cost report; and

(ii) Applied from the midpoint of the report period used to develop the cost-to-charges percentage in §B(2)(a) of this regulation, to the midpoint of the prospective payment period.

(3) Effective for dates of service starting July 1, 2012, and forward, the rates calculated for FY 2012 in accordance with §B(2) of this regulation shall be increased by 9 percent.

(4) The analysis shall be performed by the Program or its designee.

(5) There may not be a year-end cost settlement.

(6) Outpatient reimbursement rates are implemented in conjunction with, and are applicable to, the same dates of service as inpatient rates.

C. Submitting Cost Reports.

(1) The provider shall submit to the Department or its designee, in the form prescribed, financial and statistical data within 5 months after the end of the provider's fiscal year unless the Department grants the provider an extension or the provider discontinues participation in the Program.

(2) When reports are not received within 5 months and an extension has not been granted:

(a) For hospitals reimbursed in accordance with this regulation, the Program shall reduce the inpatient percentage of payment for that hospital by 5 percentage points, starting the calendar month after the calendar month in which the report is due, which will remain in effect until the report has been submitted, and there will be no refund; or

(b) For hospitals reimbursed according to Medicare standards and principles for retrospective cost reimbursement as described in 42 CFR §413, the Department shall:

(i) Withhold from the provider a maximum of 5 percent of the current monthly interim payment starting the calendar month after the calendar month in which the report is due and any subsequent calendar months until the report has been submitted; and

(ii) Refund withholdings at cost settlement.

(3) If a provider discontinues participation in the Program, financial and statistical data shall be submitted to the Department within 45 days after the effective date of termination.

(4) The Program shall grant an extension for submission of cost reports:

(a) Upon written request by the provider, setting forth the specific reasons for the request, if the Department determines, taking into consideration the totality of the circumstances, that the request is reasonable; or

(b) Concurrent with any extension granted to the hospital by Medicare, but not to exceed 60 days from the due date of cost reports.

(5) In addition to a reduction in payment percentage or withholding a percentage of interim payment pursuant to §C(2) of this regulation, when a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year and the provider has not received an extension, the Department may impose one or more sanctions as provided for in Regulation .12 of this chapter.

(6) When a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year or a report is submitted but the provider cannot furnish proper documentation to verify costs, the Department shall, if applicable, make final cost settlement for that fiscal year at a certain percentage of the last final per diem rates for which the Department has verified costs for that facility, provided that the rates established will not exceed the maximum per diem rates in effect when the facility's costs were last settled.

(7) For purposes of §C(1)—(6) of this regulation, reports are considered received when the submitted reports are completed according to instructions issued by the Department or its designee.

(8) When a report is received after imposing a reduction as specified in §C(2)(a) of this regulation, the rate of reimbursement calculated using the latest cost report information shall be implemented starting with the 1st day of the 4th full calendar month after the month in which the report was received by the Program.

.09 Submitting Cost Reports for Freestanding Acute Rehabilitation Hospitals.

A. The provider shall submit to the Department or its designee, in the form prescribed, financial and statistical data within 5 months after the end of the provider's fiscal year unless the Department grants the provider an extension or the provider discontinues participation in the Program.

B. For hospitals who do not submit reports within 5 months, for whom an extension has not been granted, and who are reimbursed according to Medicare standards and principles for retrospective cost reimbursement as described in 42 CFR §413, the Department shall:

(1) Withhold from the provider a maximum of 5 percent of the current monthly interim payment starting the calendar month after the calendar month in which the report is due and any subsequent calendar months until the report has been submitted; and

(2) Refund withholdings at cost settlement.

C. If a provider discontinues participation, financial and statistical data shall be submitted to the Department within 45 days after the effective date of termination.

D. The Program shall grant an extension for submission of cost reports:

(1) Upon written request by the provider, setting forth the specific reasons for the request, if the Department determines, taking into consideration the totality of the circumstances, that the request is reasonable; or

(2) Concurrent with any extension granted to the hospital by Medicare, but not to exceed 60 days from the due date of cost reports.

E. In addition to a reduction in payment percentage or withholding a percentage of interim payment pursuant to §B of this regulation, when a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year and the provider has not received an extension, the Department may impose one or more sanctions as provided for in Regulation .12 of this chapter.

F. When a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year or a report is submitted but the provider cannot furnish proper documentation to verify costs, the Department shall, if applicable, make final cost settlement for that fiscal year at a certain percentage of the last final per diem rates for which the Department has verified costs for that facility, provided that the rates established will not exceed the maximum per diem rates in effect when the facility's costs were last settled.

G. For purposes of §§A—F of this regulation, reports are considered received when the submitted reports are completed according to instructions issued by the Department or its designee.

.10 Cost Settlement for Freestanding Acute Rehabilitation Hospitals.

A. Retrospective Cost Reimbursement for Freestanding Acute Rehabilitation Hospitals.

(1) An acute rehabilitation hospital not approved by the Program for reimbursement according to HSCRC rates shall be reimbursed according to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR §413, or on the basis of charges if less than reasonable cost.

(2) In calculating retrospective cost reimbursement rates, the Department or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, or groups of costs, or costs of specific groups of participants.

(3) When the cost, or group or groups of costs designated, cover services rendered to all participants, including Medical Assistance participants, operating costs applicable to all participants shall be reduced by the amount of the restricted grants, gifts, or income from endowments, thus resulting in a reduction of allowable costs.

(4) Final settlement for services in the provider's fiscal year shall be determined based on Medicare retrospective cost principles found in 42 CFR §413, adjusted for Medicaid allowable costs. Allowable costs specific to the Program shall be limited to a base year cost per discharge increased by the applicable federal rate of increase times the number of Program discharges for that fiscal year.

(5) Base Year. For purposes of determining limits on the increase of cost, in accordance with Medicare regulations, the base year shall be:

(a) For an existing provider, the first year of entering into the Program or the first year separate rates for the unit or units of service or services are approved; or

(b) For a new provider, the 12-month period immediately before the provider was initially subject to target rate increases.

(6) Initial Interim Rates. In order to establish an initial interim rate, the provider shall submit to the Department or its designee, before the beginning of the first billing period, the following:

(a) A detailed cost build-up, consistent with Medicare principles and cost finding, that supports the requested rate;

(b) A current, projected, and prior year's charge rate schedule;

(c) Finalized prior year's Medicare cost reports and the most current submission;

(d) A detailed revenue schedule; and

(e) Audited financial statements.

(7) The provider shall supply the Department or its designee the assurances necessary to establish that its customary charges to participants liable for payment on a charge basis exceed the allowable cost for these services.

(8) Initial Interim Rates for Newly Established Services or Providers.

(a) The provider shall submit to the Department or its designee, a detailed cost build-up, consistent with Medicare principles and cost finding that supports the requested rate that follows.

(b) The Department will compare the rate with a compatible facility and determine a reasonable rate that does not exceed the projected charges.

(9) Revision of Interim Rates.

(a) The provider may request an interim rate revision if the actual and projected costs exceed the interim rate by 10 percent.

(b) The provider shall furnish the Department or its designee with appropriate documentation showing the reason for the increase and other necessary comparisons.

(c) The Department will lower the provider's interim rate to closely approximate the final allowable reasonable cost based on the results of the prior year's review.

(d) The provider may request no more than one interim rate revision during the provider's fiscal year.

(10) Cost Settlement. The provider shall submit to the Department or its designee:

(a) A Medicaid cost report based on actual data using the cost reporting forms used by Medicare for retrospective cost reimbursement;

(b) A copy of its Maryland Medical Assistance log;

(c) Cost reports that are sufficient in detail to support a separate cost finding for designated Maryland Medical Assistance unique cost centers; and

(d) A finalized Medicare cost report for the cost reporting year.

(11) Final Program costs shall be Maryland Medical Assistance specific.

(12) Tentative cost settlements may not be performed on a routine basis. However, the Program reserves the right to calculate tentative settlements in limited cases, when appropriate, as determined by the Department.

(13) The Department will base final settlement on the results of the finalized Medicare cost reports.

B. The Department or its designee shall notify each provider participating in the Program of the results of the final settlement under §A(10)—(13) of this regulation.

C. Within 60 days after the provider receives the notification described in §B of this regulation, the Department shall pay the amount due to the provider regardless of whether the provider files an appeal.

D. The provider may request review of the settlement under §A(10)—(13) of this regulation by filing written notice with the Program's Appeal Board within 30 days after receipt of the notification of the results of the settlement from the Department or its designee.

E. The Appeal Board shall be composed of the following:

(1) A representative of the hospital industry who is:

(a) Knowledgeable in Medicare and Medicaid reimbursement principles; and

(b) Appointed by the Secretary of the Department;

(2) An individual who:

(a) Is employed by the State;

(b) Is knowledgeable in Medicare and Medicaid reimbursement principles;

(c) Did not participate in the verification of costs; and

(d) Is appointed by the Secretary of the Department; and

(3) A third member selected by the first two members of the Appeal Board.

F. When the Appeal Board reviews an appeal from a provider in which an Appeal Board member is employed or in which the member has a financial or personal interest, the Secretary of the Department shall designate an alternate for the member.

G. If the provider elects not to appeal to the Appeal Board:

(1) The provider shall pay the amount due within 60 days after the notification described in §B of this regulation;

(2) The provider may request a longer payment schedule within 60 days after the provider receives notification of the amount due the Program, the Department may establish, after consultation with the provider, a longer payment schedule; and

(3) The Department shall establish a longer payment schedule if, in the Department's judgment based on sufficient documentation submitted by the provider, failure to grant a longer payment schedule would:

(a) Result in financial hardship to the provider; or

(b) Have an adverse effect on the quality of participant care furnished by the facility.

H. If the provider elects to appeal to the Appeal Board, the following provisions apply:

(1) Within 30 days after a provider's filing of an appeal of the Department or its designee's determination that the provider owes money to the Program, the Department or its designee shall:

(a) Recalculate the amount due to the Program based on the verification, exclusive of the amount in controversy which is subject to the appeal; and

(b) Notify the provider of that amount;

(2) In order to enable the Department or its designee to perform this recalculation, the provider shall indicate the specific adjustment and the specific amount being appealed;

(3) Subject to the provisions of §H(4) of this regulation, payment for the amount due the Program, if any, after the recalculation, shall be made within 60 days after the provider receives notification of the recalculation; and

(4) If a provider requests a longer payment schedule within 60 days after the provider receives notification of the recalculation, the Department may establish, after consultation with the provider, a longer payment schedule in accordance with §G(3) of this regulation.

I. Appeal Board Findings.

(1) After the Department receives the findings of the Appeal Board, the Department shall:

(a) Determine the amount that is due either to the Program or to the provider; and

(b) Notify the provider of that amount.

(2) The portion of the amount in controversy that is paid is subject to an award of interest that is:

(a) Calculated from the date the appeal was filed through the date of payment; and

(b) Based on the 6-month Treasury Bill rate in effect on the date the appeal was filed.

(3) Interest paid to a provider under §I(2) of this regulation is not subject to any offset or other reduction against otherwise allowable costs.

(4) If the provider accepted the determination made under §I(1) of this regulation, within 60 days after the provider receives the notification under §I(1) of this regulation, the Program shall pay the amount the Department determined is due the provider, if any.

(5) Subject to §I(6) of this regulation, within 60 days after the provider receives the notification, the provider shall pay the amount due the Program, if any.

(6) If a provider requests a longer payment schedule within 30 days after the provider receives notification of the amount due the Program, the Department may establish, after consultation with the provider, a longer payment schedule in accordance with §G(3) of this regulation.

J. After expiration of the 60-day payment period, or longer payment schedule established by the Department as described in §§G—I of this regulation, and in addition to the sanctions provided in Regulation .12 of this chapter, the Department may recover the unpaid balance by withholding the amount due from the interim payment which would otherwise be payable to the provider.

K. The Department or a provider aggrieved by a reimbursement decision of the Appeal Board may appeal the decision of the Appeal Board as the final decision for judicial review under the Administrative Procedure Act, State Government Article, §10-222, Annotated Code of Maryland.

L. If the provider or the Department appeals the final decision of the Appeal Board, the provider or the Department shall place any money due from the provider or from the Program in an interest-bearing escrow account. The money due shall include the interest, based on the rate in §I(2)(b) of this regulation, calculated from the date of the administrative appeal through the date of opening the escrow account. The money shall remain in escrow until a final decision has been rendered. Upon a final determination of the dispute, the appropriate person administering the escrow account shall distribute the money in that account, including any interest accrued, in conformity with the final determination.

M. The provider may file an appeal of the results of the settlement with the Medicare Appeal Board as a substitute for the Department's Appeal Board, and the decision rendered by the Medicare Appeal Board will be accepted by the Department as binding.

.11 Recovery and Reimbursement.

A. General policies governing recovery and reimbursement procedures applicable to all providers are set forth in COMAR 10.09.36.07.

B. If refund of a payment as specified in §A of this regulation is not made, the Department shall reduce its current payment to the

provider by the amount of the duplicate payment, overpayment, or third-party payment.

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

Causes for suspension or removal and imposition of sanctions shall be as set forth in COMAR 10.09.36.08.

.13 Appeal Procedures.

A provider filing an appeal from an administrative decision made in connection with these regulations shall do so according to COMAR 10.09.36.09.

.14 Interpretive Regulation.

General policies governing the interpretive regulations applicable to all providers are set forth in COMAR 10.09.36.10.

10.09.93 Chronic Hospitals

Authority: Health-General Article, §§2-104(b), 15-102.8, 15-103, and 15-105, Annotated Code of Maryland

.01 Definitions.

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

B. Terms Defined.

(1) "Acute hospital" means an institution that provides active, short-term medical diagnosis, treatment, and care.

(2) "Administrative day" means a day of medical services delivered to a participant who no longer requires the level of care that the provider is licensed to deliver.

(3) "Admission" means the formal acceptance by a hospital of a participant who is to be provided with room, board, and medically necessary services in an area of the hospital where individuals stay at least overnight.

(4) "Ancillary services" means diagnostic and therapeutic services including but not limited to radiology, laboratory tests, pharmacy, and physical therapy services, provided exclusive of room and board.

(5) "Appropriate facility" means:

(a) A facility located within a 25-mile radius of the participant's residence; or

(b) If acceptable to the participant, a more distant facility, which is licensed and certified to render the participant's required level of care, except when the only facility or facilities that provide the level of care and specialized services required by the participant exceed that distance.

(6) "Brain injury" means an injury or insult to the brain that occurs after birth and is not related to congenital or degenerative disease, which results in cognitive, physical, behavioral, or emotional disability that is documented in the medical record.

(7) "Brain injury community integration program" means a program located on the campus of a licensed chronic hospital and approved by the Department to treat individuals with primary diagnoses of brain injury resulting in functional limitations and disability, who need services designed to transition to home or a community-based program of services and supports.

(8) Chronic Hospital.

(a) "Chronic hospital" means an institution licensed by the Department of Health and Mental Hygiene in accordance with COMAR 10.07.01.03B, which provides services to patients with complex medical needs who do not require hospitalization in an acute hospital, but whose treatment needs exceed the capabilities of a nursing facility.

(b) "Chronic hospital" does not mean a long-term care hospital, as defined at 42 CFR §412.23(e).

(9) "Concurrent review" means a periodic reauthorization of continued medical eligibility for the level of services provided by a chronic hospital which allows for close monitoring of the participant's progress, treatment goals, and objectives, performed during an inpatient hospitalization.

(10) "Date of service" means:

(a) For inpatient hospitalizations, the date of admission into a chronic hospital up to, but not including, the date of discharge; or

(b) For outpatient services, the date services are rendered in the outpatient department of the hospital.

(11) "Department" means the Maryland Department of Health and Mental Hygiene, which is the single State agency designated to administer the Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

(12) "Designee" means any entity designated to act on behalf of the Department.

(13) "Electronic signature" means a secure electronic identification of an individual who authorizes an electronic record or transaction.

(14) "Health Services Cost Review Commission (HSCRC)" means the independent organization within the Department of Health and Mental Hygiene which is responsible for reviewing and approving rates for hospitals pursuant to Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland.

(15) "Interdisciplinary team" means a physician-led multidisciplinary clinical team consisting of, at a minimum:

(a) The participant or an individual of the participant's choice;

(b) A physician;

(c) A registered nurse;

(d) A social worker;

(e) The participant's case manager; and

(g) Any other clinical professional indicated by an individual's specific needs, including but not limited to:

(i) A psychologist;

(ii) A behavioral analyst;

(iii) A dietitian or nutritionist; and

(iv) Licensed therapists in other disciplines.

(16) "Level of care" means an assessment that an individual needs the level of services provided in a special psychiatric hospital.

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

(18) "Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with standards of good medical practice;

(c) The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the participant, family, or provider.

(19) "Medicare" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

(20) "Neuro-behavioral" means the discipline within medical rehabilitation that focuses on behavioral impairments seen in association with brain injury resulting from trauma, hypoxia, or ischemia.

(21) "Out-of-State hospital" means any hospital outside of Maryland, except for hospitals located in the District of Columbia.

(22) "Outpatient services" means services provided to the participant on the hospital campus that do not require hospital admission.

(23) "Participant" means an individual who is enrolled with the Department to receive Medical Assistance services.

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

(25) "Provider" means a chronic hospital which, through agreement with the Department, has been identified as a Program provider by the issuance of a provider number.

.02 License Requirements.

A. In order to participate in the Program, a provider shall:

(1) Be licensed by the Department pursuant to Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, as a hospital; and

(2) Obtain any other licenses required by COMAR 10.07.01.

B. The provider shall ensure that Clinical Laboratory Improvement Amendments (CLIA) certification exists for all clinical laboratory services performed, and:

(1) If located in Maryland, comply with requirements of:

(a) Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland; and

(b) COMAR 10.10.01; or

(2) If located out-of-State, comply with other applicable standards established by the state or locality in which the service is provided and with the requirements of COMAR 10.09.09.02.

C. The provider shall obtain accreditation by the Commission on Accreditation of Rehabilitation Facilities if it provides neuro-behavioral rehabilitation or brain injury services.

.03 Conditions for Participation — General.

A. A provider shall meet all conditions for participation as set forth in COMAR 10.09.36.03.

B. To participate in the Program as a chronic hospital services provider, the provider shall:

(1) Meet the requirements of Title XIX of the Social Security Act for participation as a hospital, as issued by the U.S. Department of Health and Human Services;

(2) 24 hours per day, 7 days per week, meet the following staffing requirements:

(a) On-call or on-site physician services;

(b) On-site registered nurses;

(c) On-site respiratory therapist services; and

(d) On-site advanced cardiac life support services;

(3) Directly provide or make available through contractual arrangements or transfer agreements, medically necessary covered services;

(4) Accept payment by the Program as payment in full for the covered service;

(5) Make available to the Department or its designee the participant's medical record for review and certification of medical necessity for admission and continuation of stay; and

(6) Maintain documentation of each contact with the participant as part of the complete medical record, which, at a minimum, includes:

(a) Date of service;

(b) The participant's chief medical complaint or reason for admission;

(c) A description of the services provided, including:

(i) Progress notes;

(ii) Imaging studies;

(iii) Laboratory results;

(iv) Medication administration records; and

(v) Discharge summary; and

(d) A signature, electronic or handwritten, along with the printed or typed name of the individual providing care, with the appropriate title.

.04 Specific Conditions for Provider Participation — Brain Injury Community Integration Program.

A. To participate in the Program as a provider operating a brain injury community integration program, the provider shall be:

(1) Accredited by the Commission on Accreditation of Rehabilitation Facilities; and

(2) Approved by the Department to provide the Program.

B. Staff Requirements. In addition to the requirements in Regulation .03 of this chapter, a brain injury community integration program shall meet staffing requirements, as approved by the Program, necessary to provide the neuro-behavioral management programming set forth in Regulation .05D of this chapter.

C. At least annually, in a form specified by the Program, a provider operating a brain injury community integration program shall report on the individuals admitted to and participating in the program, including:

(1) Length of stay;

(2) Discharge setting; and

(3) Any other data specified by the Program.

.05 Covered Services.

A. Chronic hospitals shall provide the following services:

(1) Complex respiratory care services;

(2) Complex wound care services;

(3) Services for participants with multiple co-morbidities, including but not limited to services necessary to care for:

(a) Ventilator-assisted individuals who have been ventilator dependent for less than 6 months and who need further medical stabilization or are candidates for weaning from ventilator assistance;

(b) Tracheostomy participants who require suctioning more frequently than every 2 hours or are candidates for decannulation;

(c) More than two extensive stage IV decubiti which require daily intensive treatment that is not available in a nursing facility; or

(d) Extensive post-operative or post-traumatic care with multiple drains or extensive dressing change or therapies beyond the capabilities of a nursing facility;

(4) For participants admitted for intensive rehabilitation services, at least two sessions, 5 days per week, of physical therapy, occupational therapy, or speech therapy focused on language pathology; and

(5) Ancillary services.

B. Treatment Plan.

(1) Within 24 hours of a participant's admission, a physician shall perform a documented face-to-face evaluation of the participant and begin developing an individualized treatment plan designed to meet the participant's assessed needs.

(2) By the 7th day of a participant's admission, an interdisciplinary team shall establish a written, individualized treatment plan for the participant, which shall include, at a minimum:

(a) Diagnoses;

(b) Treatment goals;

(c) Frequency of interventions for each type of service ordered;

(d) Duration of treatment of each type of service ordered; and

(e) Prognosis.

(3) The physician-led interdisciplinary team shall update the individualized treatment plan weekly until discharge.

C. The Program covers outpatient hospital services provided by a chronic hospital when the services are:

(1) Medically necessary; and

(2) Provided to individuals who are eligible for Medical Assistance and who are not current inpatients at the chronic hospital,

except when payment for certain outpatient services provided to a participant on the date of inpatient admission or within 3 calendar days before the date of an inpatient admission are bundled, in accordance with 42 CFR §412.2(c)(5).

D. The program covers the following brain injury community integration program services:

(1) Neuro-behavioral management programming, which includes, but is not limited to:

(a) Assessment of maladaptive behaviors using valid and reliable behavioral measurement tools;

(b) Pharmacologic intervention provided to manage maladaptive behaviors related to brain injury;

(c) Neuro-behavioral programming created, implemented, overseen, and revised as needed;

(d) Incorporation of neuro-behavioral programming into therapy and care for participants in the community integration program; and

(e) Referral to a neuro-psychiatrist, as needed, if a neuro-psychiatrist is not a member of the facility staff;

(2) Cognitive skills adaptation and compensation programming, including:

(a) Specific programming dedicated to cognitive skills adaptation and compensation; and

(b) Incorporation of cognitive compensatory strategies into community integration program participant's interdisciplinary team treatment;

(3) Community re-entry programming, including specific programming dedicated to social or pragmatic skills, leisure skills, and life skills; and

(4) According to the participant's needs:

(a) The services of a psychiatrist or psychiatric nurse;

(b) Services and supports related to substance use disorders and other addictions;

(c) Speech therapy, which includes but is not limited to:

(i) Cognitive skills;

(ii) Communication skills;

(iii) Swallowing ability; and

(iv) Linguistic programming that assists the patient to connect the meaning of words to their context;

(d) Occupational therapy, which includes but is not limited to:

(i) Instrumental activities of daily living; and

(ii) Community re-entry activities;

(e) Physical therapy, which includes but is not limited to:

(i) Ambulation; and

(ii) Motor planning and coordination;

(f) Dietary services, which includes but is not limited to nutritional needs assessment and monitoring; and

(g) Case management, which includes but is not limited to:

(i) Treatment planning; and

(ii) Discharge planning.

E. The Program covers administrative days approved by the Department or its designee according to the conditions set forth in Regulation .08C of this chapter.

.06 Limitations.

The Program does not cover:

A. Services for individuals who are not eligible for Medicaid;

B. Services for individuals who are not medically eligible for chronic hospital services;

C. Services identified by the Department or its designee as not medically necessary;

D. Hospital services, procedures, drugs, or hospital admissions that are investigational or experimental;

E. Duplicated care or services;

F. Interpretation of laboratory tests or panels;

G. Inpatient and outpatient diagnostic and laboratory services not ordered by the attending physician or other practitioner involved in the participant's care; or

H. Telephones, televisions, or personal comfort items or services.

.07 Medical Eligibility.

A. General Requirements.

(1) An admission to a chronic hospital is medically necessary for a participant whose:

(a) Medical condition is not stabilized subsequent to a course of treatment at an acute hospital, or whose deteriorating medical condition resulted in a readmission to an acute hospital from a nursing facility or community setting; and

(b) Service and care needs require active and continuing medical treatment at an intensity and frequency not provided in a nursing facility, as defined in COMAR 10.09.10.01B, such as:

(i) 24-hour availability of a physician, physician assistant, or nurse practitioner, and associated nursing staff; and

(ii) Active and continuing medical treatment by a physician at least three times per week as documented in the medical record, physician orders, and physician progress notes.

(2) An admission to a chronic hospital is medically necessary for a participant who needs intensive rehabilitation services other than those provided in a special rehabilitation hospital.

(3) A participant who may not be able to fully participate in a chronic hospital rehabilitation program may be admitted for a brief trial period of inpatient care after review by the Department or its designee and approval by the Program. If no progress on rehabilitative goals occurs, the participant shall be discharged to a lower level of care.

B. Medical Criteria for Brain Injury Community Integration Programs. In order to be preauthorized by the Program for services in a brain injury community integration program, a participant:

(1) Shall have a primary diagnosis of brain injury;

(2) Shall be at low risk of potential medical instability;

(3) May not require acute inpatient physical rehabilitation services;

(4) Shall require an intensive neuro-behavioral or neuro-cognitive rehabilitation program at a chronic level of care as described in §A of this regulation in order to:

(a) Address pervasive and persisting maladaptive behaviors, or behavioral health risk factors, that preclude a safe discharge to the community or to a less restrictive setting; and

(b) Relearn basic living and adaptive skills;

(5) Shall have potential for achievement of specific functional outcomes with the potential of improving functional ability so that discharge to a less restrictive setting is a reasonable goal;

(6) Shall need rehabilitative programming, which may include:

(a) Recreation therapy;

(b) Speech language pathology;

(c) Occupational therapy;

(d) Physical therapy; and

(e) Neuro-psychology;

(7) Shall require at least two contacts daily within the rehabilitative programming that address the neuro-behavioral or neuro-cognitive needs of the participant;

(8) Shall require active and continued clinical treatment by a physician who is experienced in neuro-rehabilitation and in psychopharmacology for a minimum of three contacts per week;

(9) Shall require a structured and integrated environment of care that provides on-going behavioral programming designed to reduce maladaptive behaviors that are reinforced by clinical support and administrative staff;

(10) Shall make progress toward the achievement of specified functional outcomes; and

(11) Shall have the ability to participate in the required number of therapy sessions.

.08 Utilization Review.

A. Admission and Prior Approval.

(1) For participants and individuals who have applied for Medical Assistance, the provider shall request a determination from the Department or its designee at the time of admission, or at the time of application for Medical Assistance, that the individual meets the medical eligibility criteria set forth in Regulation .07A of this chapter.

(2) For a participant to be preauthorized for services in a brain injury community integration program, the provider shall request a determination from the Department or its designee that the participant meets the criteria set forth in Regulation .07B of this chapter.

(3) If the provider obtains the determination set forth in §A(1) or (2) of this regulation after admission, the eligibility determination shall be effective on the date that the determination was requested.

B. Concurrent Review.

(1) On a monthly basis, the provider shall notify the Department or its designee of all persons who have:

(a) Received an initial determination of medical eligibility for chronic hospital services;

(b) Been determined to continue to meet medical eligibility criteria for chronic hospital services;

(c) Been discharged; or

(d) Been determined to no longer be medically eligible.

(2) Concurrent review shall be conducted as long as the participant remains hospitalized, based on the participant's diagnosis and condition, to ensure the medical necessity of the participant's inpatient stay, at the following intervals:

(a) After an initially authorized 30-day stay, or at the end of the expected length of stay identified at admission, whichever comes first; and

(b) Every 14 days following the initial concurrent review, including clinical updates, on a form determined by the Department or its designee.

(3) The Department or its designee may conduct on-site reviews.

C. Administrative Days.

(1) To be paid for administrative days, the provider shall document, in a form designated by the Department, information which satisfies the conditions listed below:

(a) The participant who was initially eligible has been determined to no longer require chronic hospital services, and the provider has:

(i) Received a determination from the Department or its designee that the participant requires the level of service provided by a nursing facility but an appropriate facility is not available;

(ii) Established a plan for discharge during the period of administrative days, is actively pursuing placement at an appropriate level of care for the participant, and has documented this activity in the participant's record; and

(iii) Submitted documentation to the Department or its designee that placement activity was conducted no fewer than 3 days per week during the period for which payment is requested for administrative days; or

(b) The participant is no longer medically eligible to receive chronic hospital services but cannot be moved, and the following conditions are met:

(i) The medical reason the participant cannot be moved is documented by the attending physician in the participant's medical record;

(ii) The attending physician reevaluates the medical cause of the participant's inability to be moved at least once every 7 days; and

(iii) The provider documents the active treatments used to resolve the medical cause of the participant's inability to be moved;

(2) To receive reimbursement for administrative days, the provider shall document that it has met the conditions of §C(1) of this regulation, at least every 14 days.

(3) Documentation shall be submitted to the Department or its designee no later than 3 business days following the end of the 14-day period.

.09 Payment Procedures.

A. Reimbursement of Maryland Chronic Hospitals.

(1) In-State chronic hospitals shall be reimbursed according to:

(a) Rates approved by the HSCRC pursuant to COMAR 10.37.03; or

(b) The administrative day rate as follows:

(i) For a participant who is not ventilator-dependent, payment for approved administrative days shall be the estimated Statewide average Medicaid nursing facility payment rate as determined by the Department; and

(ii) For a participant who is ventilator-dependent, payment for approved administrative days shall be the estimated average Medicaid nursing facility payment rate for ventilator-dependent residents as determined by the Department.

(2) State-operated chronic hospitals shall be reimbursed according to Regulation .10 of this chapter. The Department shall make no direct reimbursement to any State-operated chronic hospital.

B. Reimbursement of Out-of-State Hospitals.

(1) The Department shall reimburse an out-of-State hospital that provides a level of service equivalent to that provided at a chronic hospital only if:

(a) The proposed admission is first reviewed by the Department or its designee and the out-of-State placement is determined medically necessary according to Regulation .07A of this chapter;

(b) The hospital possesses the same certifications and accreditations as the Program requires for a comparable level of services and specific program in a Maryland chronic hospital; and

(c) The hospital meets one of the following conditions:

(i) The hospital proposes to provide a service or specific treatment that the participant cannot obtain in a Maryland chronic hospital; or

(ii) The hospital is located geographically closer to the established residence of the participant than a Maryland chronic hospital.

(2) The Department shall reimburse an out-of-State hospital at the lesser of:

(a) The average rate established by the HSCRC for an equivalent cost center for a Maryland chronic hospital; or

(b) The rate charged by the out-of-State hospital pursuant to 42 CFR Part 412, Subpart O.

.10 Cost Reporting—State-Operated Chronic Hospitals.

A. The provider shall submit to the Department or its designee, in the form prescribed, financial and statistical data within 5 months after the end of the provider's fiscal year unless the Department grants the provider an extension or the provider discontinues participation in the Program.

B. For hospitals who do not submit reports within 5 months, for whom an extension has not been granted, and who are reimbursed according to Medicare standards and principles for retrospective

cost reimbursement as described in 42 CFR §413, the Department shall:

(1) Withhold from the provider a maximum of 5 percent of the current monthly interim payment starting the calendar month after the calendar month in which the report is due and any subsequent calendar months until the report has been submitted; and

(2) Refund withholdings at cost settlement.

C. If a provider discontinues participation, financial and statistical data shall be submitted to the Department within 45 days after the effective date of termination.

D. The Program shall grant an extension for submission of cost reports:

(1) Upon written request by the provider, setting forth the specific reasons for the request, if the Department determines, taking into consideration the totality of the circumstances, that the request is reasonable; or

(2) Concurrent with any extension granted to the hospital by Medicare, but not to exceed 60 days from the due date of cost reports.

E. In addition to a reduction in payment percentage or withholding a percentage of interim payment pursuant to §B of this regulation, when a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year and the provider has not received an extension, the Department may impose one or more sanctions as provided for in Regulation .14 of this chapter.

F. When a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year or a report is submitted but the provider cannot furnish proper documentation to verify costs, the Department shall, if applicable, make final cost settlement for that fiscal year at a certain percentage of the last final per diem rates for which the Department has verified costs for that facility, provided that the rates established will not exceed the maximum per diem rates in effect when the facility's costs were last settled.

G. For purposes of §§A—F of this regulation, reports are considered received when the submitted reports are completed according to instructions issued by the Department or its designee.

.11 Cost Settlement — State-operated Chronic Hospitals.

A. Final settlement for services in the provider's fiscal year shall be determined based on Medicare retrospective cost principles found at 42 CFR §413, adjusted for Program allowable costs. Allowable costs specific to the Program shall be limited to a base year cost per discharge increased by the applicable federal rate of increase times the number of Program discharges for that fiscal year.

B. Base Year. For purposes of determining limits on the increase of cost, in accordance with Medicare regulations, the base year for an existing provider shall be the first year of entering into the Program or the first year separate rates for the unit or units of service or services are approved.

C. The provider shall supply the Department or its designee the assurances necessary to establish that its customary charges to participants liable for payment exceed the allowable cost for these services.

D. Revision of Interim Rates. The provider may request an interim rate revision should the actual and projected cost exceed the interim rate by 10 percent. The provider shall furnish the Department or its designee with appropriate schedules showing the reason for the increase and any other information supporting the request. The Department will lower the provider's interim rate to closely approximate the final allowable reasonable cost based on the results of the prior year's review. The provider may request not more than two interim rate revisions during the accounting year.

E. Cost Settlement. The provider shall submit to the Department or its designee a Medicaid cost report based on actual data using the cost reporting forms used by Medicare for retrospective cost reimbursement. The provider shall also submit a copy of its Maryland Medical Assistance log. The submitted cost report shall be in sufficient detail to support a separate cost finding for designated Maryland Medical Assistance unique cost centers. Tentative cost settlements may not be performed on a routine basis. However, the Program reserves the right to calculate tentative settlements in limited cases, when appropriate, as determined by the Department. The provider shall furnish the Department or its designee with a finalized Medicare cost report for the cost reporting year. The Department will base final settlement on the results of the finalized Medicare cost reports.

.12 Cost Settlement for State-operated Chronic Hospitals — Payments and Appeals.

A. The Department or its designee shall notify each provider participating in the Program of the results of the final settlement under Regulation .11 of this chapter.

B. Within 60 days after the provider receives the notification described in §A of this regulation, the Department shall pay the amount due to the provider regardless of whether the provider files an appeal.

C. The provider may request review of the settlement under Regulation .11 of this chapter by filing written notice with the Program's Appeal Board within 30 days after receipt of the notification of the results of the settlement from the Department or its designee.

D. The Appeal Board shall be composed of the following:

(1) A representative of the hospital industry who is:

(a) Knowledgeable in Medicare and Medicaid reimbursement principles; and

(b) Appointed by the Secretary of the Department;

(2) A person who:

(a) Is employed by the State;

(b) Is knowledgeable in Medicare and Medicaid reimbursement principles;

(c) Did not participate in the verification of costs; and

(d) Is appointed by the Secretary of the Department; and

(3) A third member selected by the first two members of the Appeal Board.

E. When the Appeal Board reviews an appeal from a provider in which an Appeal Board member is employed or in which the member has a financial or personal interest, the Secretary of the Department shall designate an alternate for the member.

F. If the provider elects not to appeal to the Appeal Board:

(1) The provider shall pay the amount due within 60 days after the notification described in §A of this regulation;

(2) If the provider requests a longer payment schedule within 60 days after the provider receives notification of the amount due the Program, the Department may establish, after consultation with the provider, a longer payment schedule; and

(3) The Department shall establish a longer payment schedule if, in the Department's judgment based on sufficient documentation submitted by the provider, failure to grant a longer payment schedule would:

(a) Result in financial hardship to the provider; or

(b) Have an adverse effect on the quality of participant care furnished by the facility.

G. If the provider elects to appeal to the Appeal Board, the following provisions apply:

(1) Within 30 days after a provider appeals a determination by the Department or its designee that the provider owes money to the Program, the Department or its designee shall:

(a) Recalculate the amount due to the Program based on the verification, exclusive of the amount in controversy which is subject to the appeal; and

(b) Notify the provider of that amount;

(2) In order to enable the Department or its designee to perform this recalculation, the provider shall indicate the specific adjustment and the specific amount being appealed;

(3) Subject to the provisions of §G(4) of this regulation, payment for the amount due the Program, if any, after the recalculation, shall be made within 60 days after the provider receives notification of the recalculation; and

(4) If a provider requests a longer payment schedule within 60 days after the provider receives notification of the recalculation, the Department may establish, after consultation with the provider, a longer payment schedule in accordance with §F(3) of this regulation.

H. Appeal Board Findings.

(1) After the Department receives the findings of the Appeal Board, the Department shall:

(a) Determine the amount that is due either to the Program or to the provider; and

(b) Notify the provider of that amount.

(2) The portion of the amount in controversy that is paid is subject to an award of interest that is:

(a) Calculated from the date the appeal was filed through the date of payment; and

(b) Based on the 6-month Treasury Bill rate in effect on the date the appeal was filed.

(3) Interest paid to a provider under §H(2) of this regulation is not subject to any offset or other reduction against otherwise allowable costs.

(4) If the provider accepted the determination made under §H(1) of this regulation, within 60 days after the provider receives the notification under §H(1) of this regulation, the Program shall pay the amount the Department determined is due the provider, if any.

(5) Subject to §H(6) of this regulation, within 60 days after the provider receives the notification, the provider shall pay the amount due the Program, if any.

(6) If a provider requests a longer payment schedule within 30 days after the provider receives notification of the amount due the Program, the Department may establish, after consultation with the provider, a longer payment schedule in accordance with §F(3) of this regulation.

I. After expiration of the 60-day payment period, or longer payment schedule established by the Department as described in §§F—H of this regulation, and in addition to the sanctions provided in Regulation .14 of this chapter, the Department may recover the unpaid balance by withholding the amount due from the interim payment which would otherwise be payable to the provider.

J. The Department or a provider aggrieved by a reimbursement decision of the Appeal Board may appeal the decision of the Appeal Board as the final decision for judicial review under the Administrative Procedure Act, State Government Article, §10-222, Annotated Code of Maryland.

K. If the provider or the Department appeals the final decision of the Appeal Board, the provider or the Department shall place any money due from the provider or from the Program in an interest-bearing escrow account. The money due shall include the interest, based on the rate in §H(2)(b) of this regulation, calculated from the date of the administrative appeal through the date of opening the escrow account. The money shall remain in escrow until a final decision has been rendered. Upon a final determination of the dispute, the appropriate person administering the escrow account shall distribute the money in that account, including any interest accrued, in conformity with the final determination.

L. The provider may file an appeal of the results of the settlement with the Medicare Appeal Board as a substitute for the Department's Appeal Board, and the decision rendered by the Medicare Appeal Board will be accepted by the Department as binding.

.13 Recovery and Reimbursement.

A. General policies governing recovery and reimbursement procedures applicable to all providers are set forth in COMAR 10.09.36.07.

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

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

Causes for suspension or removal and imposition of sanctions shall be as set forth in COMAR 10.09.36.08.

.15 Appeal Procedures.

A provider filing an appeal from an administrative decision made in connection with these regulations shall do so according to COMAR 10.09.36.09.

.16 Interpretive Regulation.

General policies governing the interpretive regulations applicable to all providers are set forth in COMAR 10.09.36.10.

10.09.94 Special Pediatric Hospitals

Authority: Health-General Article, §§2-104(b), 15-102.8, 15-103, and 15-105, Annotated Code of Maryland

.01 Definitions.

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

B. Terms Defined.

(1) "Acute hospital" means an institution that provides active, short-term medical diagnosis, treatment, and care.

(2) "Administrative day" means a day of medical services delivered to a participant who no longer requires the level of care that the provider is licensed to deliver.

(3) "Admission" means the formal acceptance by a hospital of a participant who is to be provided with room, board, and medically necessary services in an area of the hospital where patients stay at least overnight.

(4) "Ancillary services" means diagnostic and therapeutic services including but not limited to radiology, laboratory tests, pharmacy, and physical therapy services, provided exclusive of room and board.

(5) "Appropriate facility" means:

(a) A facility located within a 25-mile radius of the participant's residence; or

(b) If acceptable to the participant, a more distant facility, which is licensed and certified to render the participant's required level of care, except when the only facility or facilities that provide the level of care and specialized services required by the participant exceed that distance.

(6) "Concurrent review" means a periodic reauthorization of continued medical eligibility for the level of services provided by a special pediatric hospital, which allows for close monitoring of the participant's progress, treatment goals, and objectives, performed during an inpatient hospitalization.

(7) "Date of service" means:

(a) For inpatient hospitalizations, the date of admission into a special pediatric hospital up to, but not including, the date of discharge; or

(b) For outpatient services, the date services are rendered in the outpatient department of the hospital.

(8) "Department" means the Maryland Department of Health and Mental Hygiene, which is the single State agency designated to administer the Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

(9) "Designee" means any entity designated to act on behalf of the Department.

(10) "Diagnosis-related group" means a participant classification system adopted by the U.S. Department of Health and Human Services, in which each hospital discharge case is assigned a category based on the primary diagnosis, secondary diagnoses, if any, procedures performed, and age, sex, and discharge status of the participant.

(11) "Electronic signature" means a secure electronic identification of an individual who authorizes an electronic record or transaction.

(12) "Health Services Cost Review Commission (HSCRC)" means the independent organization within the Department of Health and Mental Hygiene which is responsible for reviewing and approving rates for hospitals pursuant to Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland.

(13) "Level of care" means an assessment that an individual needs the level of services provided in a special psychiatric hospital.

(14) "Maryland Medical Assistance Program" means the program of comprehensive medical and other health-related care for indigent and medically indigent persons.

(15) "Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with standards of good medical practice;

(c) The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the participant, family, or provider.

(16) "Medicare" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

(17) "Out-of-State hospital" means any hospital outside of Maryland, except for hospitals located in the District of Columbia.

(18) "Outpatient services" means services provided to the participant on the hospital campus that do not require hospital admission.

(19) "Participant" means an individual who is enrolled with the Department to receive Medical Assistance services.

(20) "Plan of treatment" means a written plan developed by a participant's consulting physician and other appropriate clinicians, which is provided to the Department on request and includes:

(a) Diagnosis;

(b) Treatment goals;

(c) Specific procedures planned for the participant, including surgeries;

(d) Duration of treatment of each type of service ordered;

(e) Expected length of stay; and

(f) Any other appropriate information, including caregiver education and discharge plan.

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

(22) "Prospective payment system" means a predetermined amount of reimbursement per day for inpatient hospital services.

(23) "Provider" means a special pediatric hospital which, through agreement with the Department, has been identified as a Program provider by the issuance of a provider number.

(24) Special Pediatric Hospital.

(a) "Special pediatric hospital" means a facility licensed by the Office of Health Care Quality as a special hospital that provides nonacute medical, rehabilitation, therapy, and palliative services to children and adolescents younger than 22 years old.

(b) "Special pediatric hospital" includes an out-of-State or District of Columbia hospital identified by the Program as:

(i) A facility that provides nonacute medical, rehabilitation, therapy, and palliative services to children and adolescents younger than 22 years old; and

(ii) A facility that provides nonacute medical, rehabilitation, and therapy services to individuals ages 2 through 22 with co-occurring medical and behavioral conditions.

.02 License Requirements.

A. In order to participate in the Program, a provider shall:

(1) Be licensed by the Department pursuant to Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, as a hospital; and

(2) Obtain other licenses, as set forth in COMAR 10.07.01.

B. The provider shall ensure that Clinical Laboratory Improvement Amendments (CLIA) certification exists for all clinical laboratory services performed, and:

(1) If located in Maryland, comply with requirements of:

(a) Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland; and

(b) COMAR 10.10.01; or

(2) If located out-of-State, comply with other applicable standards established by the state or locality in which the service is provided and with the requirements of COMAR 10.09.09.02.

.03 Conditions for Participation.

A. A provider shall meet all conditions for participation as set forth in COMAR 10.09.36.

B. To participate in the Program as a special pediatric hospital services provider, the provider shall:

(1) Meet the requirements of Title XIX of the Social Security Act for participation as a hospital, as issued by the U.S. Department of Health and Human Services;

(2) Directly provide, or make available through contractual arrangements or transfer agreements, medically necessary covered services;

(3) Accept payment by the Program as payment in full for the covered services;

(4) Make available to the Department or its designee the participant's medical record for review and certification of medical necessity for admission and continuation of stay; and

(5) Maintain documentation of each contact with the participant as part of the complete medical record, which, at a minimum, includes:

(a) Date of service;

(b) The participant's chief medical complaint or reason for admission or outpatient visit;

(c) A description of the services provided, including:

(i) Progress notes;

(ii) Imaging studies;

(iii) Laboratory results;

(iv) Medication administration records; and

(v) Discharge summary; and

(d) A signature, electronic or handwritten, along with the printed or typed name of the individual providing care, with the appropriate title.

C. If an out-of-State or District of Columbia hospital, the hospital shall:

(1) Have in effect a utilization review plan applicable to all participants who receive Medical Assistance under Title XIX of the Social Security Act which meets the requirements of §1861(k) of the Social Security Act unless a waiver has been granted by the Secretary of Health and Human Services; and

(2) Allow HealthChoice managed care organizations to pay no more and no less than the reimbursement rates established in

Regulation .07 of this chapter unless the parties mutually agree to an alternative arrangement in a contract either on or after July 1, 2011.

.04 Covered Services.

A. The Program covers the following inpatient services at special pediatric hospitals:

(1) A hospital admission determined to be medically necessary for a participant who is stable enough for transfer to a post-acute setting and requires medical or rehabilitative services that:

(a) Cannot be provided at a lower level of care; and

(b) Meets the medical eligibility criteria under Regulation .06 of this chapter;

(2) Administrative days for the length of time certified by the Department or its designee;

(3) Inpatient admissions for intensive occupational therapy, physical therapy, or speech therapy on a regimen which is less than 3 hours per day, 5 days per week, when these services are provided in a unit that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide rehabilitation services; and

(4) Ancillary services.

B. The Program covers the following outpatient hospital services:

(1) Medically necessary services for the provision of diagnostic, curative, palliative, or rehabilitative treatment; and

(2) For a participant younger than 21 years old, physical therapy, occupational therapy, speech therapy, and audiology services if:

(a) The therapy provider develops a written plan of treatment in collaboration with the participant's primary care physician and the participant or the parent or guardian of the participant;

(b) The service is provided according to the plan of treatment; and

(c) The services provider sends an update of the plan of treatment to the participant's primary care physician every 90 days.

.05 Limitations.

The Program does not cover:

A. Investigational or experimental hospital services, procedures, or drugs;

B. Inpatient admissions or outpatient visits solely for the administration of injections, unless medical necessity and the participant's inability to take appropriate oral medications is documented in the participant's medical record;

C. Outpatient visits intended to accomplish one or more of the following:

(1) Prescription drug or food supplement pick-up;

(2) Collection of specimens for laboratory procedures;

(3) Recording of an electrocardiogram; or

(4) Ascertaining the participant's weight;

D. Interpretation of laboratory tests or panels;

E. Autopsies;

F. Immunizations required for travel outside the continental United States;

G. Leaves of absence beyond the period of the census check of the same day;

H. Day care;

I. Psychological evaluations and treatments except when:

(1) Ordered by a physician, and the medical necessity is documented in the participant's medical record; or

(2) Performed as mental health service, as part of the plan of treatment;

J. Duplicated care or services;

K. Elective admissions to hospitals outside of Maryland and the District of Columbia unless the Department or its designee determines that comparable services are not available in Maryland, except under certain conditions where child participants are in foster care, or are for other reasons placed outside the State and are covered under certain criteria, as determined by the Department or its designee;

L. Inpatient and outpatient diagnostic services not specifically ordered by the attending physician or other responsible practitioner;

M. Inpatient days or services provided in excess of the days approved by the Department or its designee;

N. Hospital laboratory tests which are coverable under COMAR 10.09.09.04, if the specimen is not obtained in the hospital;

O. Hospital services provided outside of the United States;

P. The completion of forms and reports;

Q. Broken or missed appointments;

R. Professional services rendered by mail or telephone; or

S. Telephones, televisions, or personal comfort items or services.

.06 Utilization Review.

A. The Department or its designee shall conduct utilization review to determine that special pediatric hospital admissions and outpatient services are authorized only when medically necessary.

B. Review Procedure.

(1) For all admissions, the special pediatric hospital shall provide:

(a) The elements of a participant's medical record specified by the Department or its designee for preadmission review, and request to certify the participant's admission; and

(b) Sufficient clinical information or documentation to the Department or its designee that supports the need for admission to a special pediatric hospital including, but not limited to:

(i) Current medical health status;

(ii) Treatment received to date;

(iii) Proposed treatment plan for requested admission; and

(iv) Expected length of stay.

(2) Admission for inpatient services may be authorized only when these services cannot be provided:

(a) On an outpatient basis; or

(b) In a facility that is licensed to provide a more appropriate level of care to the participant.

(3) Concurrent review shall be conducted as long as the participant remains hospitalized, based on the participant's diagnosis and condition, to ensure the medical necessity of the participant's inpatient stay, at the following intervals:

(a) After an initially authorized 14-day stay, or at the end of the expected length of stay identified at admission, whichever comes first; and

(b) Every 14 days following the initial concurrent review, in a form and including clinical documentation as specified by the Department or its designee.

(4) The Department or its designee may conduct on-site reviews after an initially authorized period of 30 days, and every 30 days thereafter until discharge.

(5) An elective inpatient hospital admission requires preadmission authorization by the Department or its designee.

C. Administrative Days.

(1) To be paid for administrative days, the provider shall document, in a form designated by the Department, information which satisfies the conditions listed below:

(a) The participant has been determined to no longer require special pediatric hospital services, and the provider has:

(i) Received a determination from the Department or its designee that the participant requires the level of service provided in a lower-acuity facility, but an appropriate facility is not available;

(ii) Established a plan for discharge during the period of administrative days, is actively pursuing placement at an appropriate

level of care for the participant, and has documented this activity in the participant's record; and

(iii) Submitted documentation to the Department or its designee that placement activity was conducted no fewer than 3 days per week during the period for which payment is requested for administrative days; or

(b) The participant is no longer medically eligible to receive special pediatric hospital services but cannot be moved, and the following conditions are met:

(i) The medical reason the participant cannot be moved is documented by the attending physician in the participant's medical record;

(ii) The attending physician reevaluates the medical cause of the participant's inability to be moved at least once every 7 days; and

(iii) The provider documents the active treatments used to resolve the medical cause of the participant's inability to be moved;

(2) To receive reimbursement for administrative days, the provider shall document that it has met the conditions of §C(1) of this regulation, at least every 14 days.

(3) Documentation shall be submitted to the Department or its designee no later than 3 business days following the end of the 14-day period.

.07 Payment Procedures.

A. HSCRC Reimbursement Principles.

(1) Except for hospitals reimbursed under the provisions of §B of this regulation and except for administrative days, hospitals located in Maryland that participate in the Program shall charge and be reimbursed according to rates approved by the HSCRC pursuant to COMAR 10.37.03.

(2) If the Program discontinues using rates which have been approved by HSCRC, the Program shall reimburse a provider:

(a) According to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR §413; or

(b) On the basis of charges if less than reasonable cost.

(3) The Department may not reimburse for the services of a hospital's salaried or contractual physicians as a separate line item.

B. Annual Market Basket Reimbursement Principles.

(1) Except as specified in §B(2)—(5) of this regulation, a special pediatric hospital not approved by the Program for reimbursement according to HSCRC rates shall be reimbursed according to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR §413, or on the basis of charges if less than reasonable cost. In calculating retrospective cost reimbursement rates, the Department or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, or groups of costs, or costs of specific groups of participants. When the cost, or group or groups of costs designated, cover services rendered to all participants, including Medical Assistance participants, operating costs applicable to all participants shall be reduced by the amount of the restricted grants, gifts, or income from endowments, thus resulting in a reduction of allowable costs.

(2) For days of service on or after July 1, 2006, in special pediatric hospitals with pediatric rehabilitation beds in Maryland not approved by the Program for reimbursement according to HSCRC rates, the Department shall reimburse these hospitals using a prospective payment system consisting of per diem rates based on service categories audited and adjusted in the provider's fiscal year 2004 cost report. The base per diem rates shall be:

(a) Annually adjusted by the factor indicated in the Centers for Medicare and Medicaid Services Annual Market Basket Update Factor for the Long Term Care Hospital Prospective Payment System; and

(b) Determined by allocating Medicaid inpatient costs into service categories as follows:

(i) Rehabilitation categories — $1,486.58;

(ii) Feeding categories — $2,213.98;

(iii) Severe behavior categories — $2,544.66; and

(iv) Other categories — $1,126.69.

(3) For new services established after July 1, 2006, in special pediatric hospitals with pediatric rehabilitation beds in Maryland not approved by the Program for reimbursement according to HSCRC rates, the Program shall pay at an initial rate that is set as an interim rate at the Medicaid weighted average rate of all existing inpatient per diem rates. After the first full year, actual cost data shall be used to prospectively set the new service rate.

(4) For days of service on or after July 1, 2006, in special pediatric hospitals with pediatric rehabilitation beds in Maryland not approved by the Program for reimbursement according to HSCRC rates, the Department shall reimburse hospital based outpatient services on a prospective basis that shall be adjusted annually by the difference between the:

(a) Medicaid weighted average charge increase; and

(b) Centers for Medicare and Medicaid Services Outpatient Prospective Payment System Market Basket Update Factor.

(5) For outpatient services in §B(4) of this regulation, the revenue shall be maintained at the fiscal year 2011 level beginning July 1, 2011.

C. Out-of-State Hospitals Reimbursement Principles.

(1) An out-of-State hospital, except a hospital located in the District of Columbia, shall be reimbursed the lesser of its charges or the amount reimbursable by the host state's Title XIX agency. The hospital shall be reimbursed for administrative days in accordance with Regulation .09E of this chapter.

(2) For outpatient services, an out-of-State hospital, except a hospital located in the District of Columbia, shall be reimbursed the lesser of its charges or the amount reimbursable by the host state's Title XIX agency.

.08 District of Columbia Hospital Reimbursement.

A. Inpatient Services Base Rate Calculation.

(1) A hospital in the District of Columbia shall:

(a) Bill its usual and customary charges; and

(b) Be reimbursed for covered services the lesser of its percentage of charges as calculated in §A(2) of this regulation or its charges.

(2) The percentage of charges in §A(1) of this regulation is the product of the following:

(a) The cost-to-charges percentage using only those costs of the hospital reported in the hospital's most recent cost report as determined by the Program or its designee;

(b) The lesser of 100 percent or the cost-to-charge projection percentage which is:

(i) The hospital's cost-to-charge ratio in its most recent cost report trended by its cost-to-charge ratio in the 2 prior years' cost reports or, if 3 years of data are not available, the hospital's cost-to-charge ratio in its most recent cost report divided by its cost-to-charge ratio in the prior year's cost report; and

(ii) Applied from the midpoint of the report period used to develop the cost-to-charges percentage in §A(2)(a) of this regulation, to the midpoint of the prospective payment period;

(c) The percentage of the hospital's costs which are efficiently and economically incurred as determined in accordance with §A(6) of this regulation; and

(d) The uncompensated care factor, which is equal to one plus the quotient of the hospital's uncompensated care divided by gross revenue.

(3) Effective for dates of service starting July 1, 2012, and forward, the rate calculated for FY 2012 in accordance with §A(2) of this regulation shall be increased by 9 percent.

(4) A hospital in the District of Columbia shall be reimbursed for administrative days in accordance with Regulation .08C of this chapter.

(5) Efficiently and economically incurred District of Columbia hospitals' costs are costs which are:

(a) Less than or equal to the adjusted costs for the same all participant refined-diagnosis related groups in Maryland hospitals;

(b) For hospitals with average lengths of stay of 18 days or more:

(i) Less than or equal to the adjusted cost for the same diagnosis-related groups in Maryland hospitals; and

(ii) Categorized into the following two age groups: younger than 18 years old, and 18 years old or older;

(c) Exclusive of:

(i) Maryland case charges greater than $500,000; and

(ii) District of Columbia hospital case charges greater than $500,000 times the ratio of the average charge of the District of Columbia hospital case divided by the average charge of the Maryland hospital case; and

(d) Derived from hospital costs as specified in this subsection.

(6) Maryland hospital costs are the hospitals' charges reduced by the hospital specific ratio of operating costs to gross charges as determined by the Program or designee.

(7) There may not be a year-end cost settlement.

(8) For hospitals located in the District of Columbia that are not acute children's hospitals, the reimbursement amount described in §A(1) of this regulation will be reduced by 2 percent.

B. Outpatient Services.

(1) A hospital located in the District of Columbia shall:

(a) Bill its usual and customary charges; and

(b) Be reimbursed for covered services the lesser of its percentage of charges as calculated in §B(2) of this regulation or its charges.

(2) The percentage of charges in §B(1) of this regulation is the product of:

(a) The cost-to-charges percentage using only those costs of the hospital reported in the hospital's most recent cost report as determined by the Program or its designee; and

(b) The lesser of 100 percent or the cost-to-charge projection percentage which is:

(i) The hospital's cost-to-charge ratio in its most recent cost report trended by its cost-to-charge ratio in the 2 prior years' cost reports or, if 3 years of data are not available, the hospital's cost-to-charge ratio in its most recent cost report divided by its cost-to-charge ratio in the prior year's cost report; and

(ii) Applied from the midpoint of the report period used to develop the cost-to-charges percentage in §B(2)(a) of this regulation, to the midpoint of the prospective payment period.

(3) Effective for dates of service starting July 1, 2012, and forward, the rates calculated for FY 2012 in accordance with §B(2) of this regulation shall be increased by 9 percent.

(4) The analysis shall be performed by the Program or its designee.

(5) There may not be a year-end cost settlement.

(6) Outpatient reimbursement rates are implemented in conjunction with, and are applicable to, the same dates of service as inpatient rates.

C. Cost Reporting.

(1) A special pediatric hospital provider reimbursed according to this regulation shall submit to the Department or its designee, in the form prescribed, financial and statistical data within 5 months after the end of the provider's fiscal year unless the Department grants the provider an extension or the provider discontinues participation in the Program.

(2) When reports are not received within 5 months and an extension has not been granted:

(a) For hospitals reimbursed in accordance with Regulation .08 of this chapter, the Program shall reduce the inpatient percentage of payment for that hospital by 5 percentage points, starting the calendar month after the calendar month in which the report is due, which will remain in effect until the report has been submitted, and there will be no refund; or

(b) For a hospital reimbursed according to Medicare standards and principles for retrospective cost reimbursement as described in 42 CFR §413, the Department shall:

(i) Withhold from the provider a maximum of 5 percent of the current monthly interim payment starting the calendar month after the calendar month in which the report is due and any subsequent calendar months until the report has been submitted; and

(ii) Refund withholdings at cost settlement.

(3) If a provider discontinues participation in the Program, financial and statistical data shall be submitted to the Department within 45 days after the effective date of termination.

(4) The Program may grant an extension for submission of cost reports:

(a) Upon written request by the provider, setting forth the specific reasons for the request, if the Department determines, taking into consideration the totality of the circumstances, that the request is reasonable; or

(b) Concurrent with any extension granted to the hospital by Medicare, but not to exceed 60 days from the due date of cost reports.

(5) When a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year, and the provider has not received an extension, the Department may impose, in addition to a reduction in payment percentage or withholding a percentage of interim payment pursuant to §C(2) of this regulation, one or more sanctions as provided for in Regulation .11 of this chapter.

(6) When a report is not submitted by the last day of the sixth month after the end of the provider's fiscal year or a report is submitted but the provider cannot furnish proper documentation to verify costs, the Department shall, if applicable, make final cost settlement for that fiscal year at a certain percentage of the last final per diem rates for which the Department has verified costs for that facility, provided that the rates established will not exceed the maximum per diem rates in effect when the facility's costs were last settled.

(7) For purposes of §C(1)—(6) of this regulation, reports are considered received when the submitted reports are completed according to instructions issued by the Department or its designee.

(8) When a report is received after imposing a reduction as specified in §C(2)(a) of this regulation, the rate of reimbursement calculated using this cost report information shall be implemented starting the 1st day of the 4th full calendar month after the month in which the report was received by the Program.

.09 Billing and Reimbursement Principles.

A. The Program shall pay room and board charges for the day of admission, and may not pay room and board charges for the day of discharge from the hospital.

B. The provider shall submit a request for payment according to procedures designated by the Department.

C. Payments of Medicare Claims.

(1) Payment of Medicare claims is authorized if:

(a) The provider accepts Medicare assignment;

(b) Medicare makes direct payment to the provider;

(c) Medicare determined that services were medically necessary;

(d) The services are covered by the Program; and

(e) Initial billing is made directly to Medicare according to Medicare guidelines.

(2) Payment of a deductible and co-insurance related to Medicare claims shall be paid subject to the HSCRC discounts, except in the case of a participant receiving hospital services in an out-of-State facility, in which case deductible and co-insurance shall be paid in full.

D. Out-of-State Hospital Reimbursement.

(1) The Program shall reimburse hospitals outside of Maryland, excluding the District of Columbia, at a rate that is 100 percent of the amount reimbursable by the host state's Title XIX agency or the amount of the hospital's actual charges in total, whichever is less.

(2) Out-of-State providers are responsible for reimbursing the Department for overpayments, in accordance with Regulation .10 of this chapter.

E. Payment for Administrative Days.

(1) The provider shall document, on forms designated by the Department, information that satisfies the conditions stated in Regulation .06C of this chapter.

(2) The provider shall:

(a) Receive determination from the Department or its designee that the participant no longer requires the level of care that the special pediatric hospital is licensed to provide;

(b) Receive determination from the Department or its designee that the participant requires services at a lower level of acuity, and a bed in an appropriate facility is not available; and

(c) Notify the Department or its designee of discharge planning before the termination of the need for inpatient hospitalization at the level the facility is licensed to provide, and obtained a level of care determination from the agent.

F. During the period of administrative days, the Department or its designee shall review the documentation in increments of not more than 14 days.

G. For participants who are not ventilator-dependent, payment for approved administrative days shall be the lesser of:

(1) An estimated Statewide average Medicaid nursing home payment rate as determined by the Department; or

(2) If the hospital has a unit which is a skilled nursing facility, the allowable costs in effect under Medicare or extended services provided to participants of the unit.

H. The Department will make no direct payment to the participant.

I. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.06.

J. The Department reserves the right to return to the provider, before payment, all invoices not properly completed.

K. Noncompliance with the Program's requirements as determined by the Department or its designee shall result in nonpayment of the claim.

L. Payment on claims to a hospital located in the District of Columbia shall be reduced by a quarterly claims processing fee of 6 percent.

.10 Recovery and Reimbursement.

A. General policies governing recovery and reimbursement procedures applicable to all providers are set forth in COMAR 10.09.36.07.

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

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

Causes for suspension or removal and imposition of sanctions shall be as set forth in COMAR 10.09.36.08.

.12 Appeal Procedures.

A provider filing an appeal from an administrative decision made in connection with these regulations shall do so according to COMAR 10.09.36.09.

.13 Interpretive Regulation.

General policies governing the interpretive regulations that are applicable to providers are set forth in COMAR 10.09.36.10.

10.09.95 Special Psychiatric Hospitals

Authority: Health-General Article, §§2-104(b), 15-102.8, 15-103, and 15-105, Annotated Code of Maryland

.01 Definitions.

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

B. Terms Defined.

(1) "Administrative day" means a day of medical services delivered to a participant who no longer requires the level of care which the provider is licensed to deliver and is awaiting placement in a nursing home or residential care facility.

(2) "Admission" means the formal acceptance by a specialty psychiatric hospital of a patient who is to be provided with room, board, and medically necessary services in an area of the hospital where patients stay at least overnight.

(3) "Ancillary services" means diagnostic and therapeutic services, provided exclusive of room and board, including but not limited to:

(a) Radiology;

(b) Laboratory tests;

(c) Pharmacy services; and

(d) Physical therapy services.

(4) "Appropriate facility" means:

(a) A facility located within a 25-mile radius of the participant's residence; or

(b) If acceptable to the participant, a more distant facility, which is licensed and certified to render the participant's required level of care, except when the only facility or facilities that provide the level of care and specialized services required by the participant exceed that distance.

(5) "Concurrent review" means a periodic reauthorization of continued eligibility for the level of services provided by a special psychiatric hospital which allows for close monitoring of the participant's progress, treatment goals, and objectives during an inpatient hospitalization.

(6) "Date of service" means:

(a) For inpatient hospitalizations, the date of admission into a special psychiatric hospital up to, but not including, the date of discharge;

(b) For outpatient services, the date services are rendered in the outpatient department of the special psychiatric hospital; and

(c) For observation services, the date or dates the services are rendered in a special psychiatric hospital, which are ordered by a medical staff practitioner to determine the need for inpatient admission.

(7) "Department" means the State Department of Health and Mental Hygiene, which is the single State agency designated to

administer the Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

(8) "Designee" means any entity designated to act on behalf of the Department.

(9) "Electronic signature" means a secure electronic identification of an individual who authorizes an electronic record or transaction.

(10) "Emergent condition" means a disease, illness, or injury characterized by sudden onset and symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(a) Placing the participant's health or, with respect to a pregnant woman, the health of the woman or unborn child in serious jeopardy;

(b) Serious impairment of bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(11) "Health Services Cost Review Commission (HSCRC)" means the independent organization within the Department of Health and Mental Hygiene which is responsible for reviewing and approving rates for hospitals pursuant to Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland.

(12) "Level of care" means an assessment that an individual needs the level of services provided in a special psychiatric hospital.

(13) "Maryland Medical Assistance Program" means the program of comprehensive medical and other health-related care for indigent and medically indigent persons.

(14) "Medicaid" means the Maryland Medical Assistance Program.

(15) "Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with standards of good medical practice;

(c) The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the participant, family, or provider.

(16) "Medicare" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

(17) "Mental health services" means those services described in COMAR 10.09.59.06 rendered to treat the diagnoses set forth in COMAR 10.09.70.02.

(18) "Nonqualified alien" means a foreign-born resident who:

(a) Is not a naturalized U.S. citizen; and

(b) Is eligible for federal Medical Assistance coverage of only emergency medical services, as specified under COMAR 10.09.24.05-2A.

(19) "Observation services" means the medically necessary diagnostic services used to assess the participant's outpatient condition to determine the need for possible admission to an inpatient special psychiatric care setting.

(20) "Organ" means a part of an organism that is typically self-contained and has a specific vital function, such as a heart or liver.

(21) "Out-of-State hospital" means any hospital outside of Maryland, except for hospitals located in the District of Columbia.

(22) "Outpatient services" means services provided to the participant on the hospital campus that do not require hospital admission.

(23) "Partial hospitalization" means outpatient, intensive, nonresidential psychiatric treatment, which is an alternative to inpatient acute general hospitalization, for any part of a 24-hour day for a minimum of 4 consecutive hours per day.

(24) "Participant" means a person who is certified as eligible for and is receiving Medical Assistance benefits.

(25) "Patient" means an individual awaiting or undergoing health care or treatment.

(26) "Plan of treatment" means a written plan, developed to address the referred problem or problems, which includes:

(a) Diagnosis;

(b) Treatment goals;

(c) Frequency of visits for each type of service ordered;

(d) Duration of treatment of each type of service ordered;

(e) Prognosis; and

(f) Other appropriate items.

(27) "Preauthorization" means the approval required from the Department or its designee before a service can be rendered by the provider and reimbursed.

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

(29) "Provider" means a special psychiatric hospital which through agreement with the Department has been identified as a Program provider by the issuance of a provider number.

(30) "Retrospective review" means the process of determining medical necessity of an inpatient admission after the participant has been discharged from the hospital.

(31) "Special psychiatric hospital" means an institution that:

(a) Provides short-term services for psychiatric illnesses in a hospital setting with facilities, medical staff, and all necessary personnel to provide diagnosis, care, and treatment;

(b) Falls within the jurisdiction of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland; and

(c) Is licensed pursuant to COMAR 10.07.01 or other applicable standards established by the state in which the service is provided.

.02 License Requirements.

A. In order to participate in the Program, a provider shall:

(1) Be licensed by the Department pursuant to Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, as a specialty psychiatric hospital; and

(2) Obtain other licenses, as set forth in COMAR 10.07.01.

B. A provider shall ensure that Clinical Laboratory Improvement Amendments (CLIA) certification exists for all clinical laboratory services performed, and:

(1) If located in Maryland, comply with requirements of:

(a) Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland; and

(b) COMAR 10.10.01; or

(2) If located out-of-State, comply with other applicable standards established by the state or locality in which the service is provided and with the requirements of COMAR 10.09.09.02.

.03 Conditions for Participation.

A. A provider shall meet all conditions for participation as set forth in COMAR 10.09.36.03.

B. To participate in the Program as a special psychiatric hospital services provider, the provider shall:

(1) Meet the requirements of Title XIX of the Social Security Act for participation as a hospital, as issued by the Department of Health and Human Services;

(2) Meet the following staffing requirements 24 hours per day, 7 days per week:

(a) On-call or on-site physician services including psychiatric physicians;

(b) On-site registered nurses;

(c) On-site advanced cardiac life support services;

(3) If licensed to provide inpatient psychiatric services for individuals younger than 21 years old:

(a) Meet the requirements for participation as defined in 42 CFR §440.160; and

(b) Provide acute psychiatric services as defined in 42 CFR Part 441, Subpart D;

(4) Directly provide or make available through contractual arrangements or transfer agreements, medically necessary covered services;

(5) Accept payment by the Program as payment in full for the covered service;

(6) Make available to the Department or its designee the participant's medical record for review and certification of medical necessity for admission and continuation of stay;

(7) Maintain documentation of each contact with the participant as part of the medical record, which, at a minimum, includes:

(a) Date of service;

(b) A plan of treatment as defined in Regulation .01B of this chapter;

(c) The participant's chief medical complaint or reason for visit;

(d) A description of the services provided, including:

(i) Progress notes;

(ii) Imaging studies;

(iii) Laboratory results;

(iv) Medication administration records; and

(v) Discharge summary; and

(e) A signature, electronic or handwritten, along with the printed or typed name of the individual providing care, with the appropriate title;

(8) Submit to the Department or its designee within 5 months of the close of the hospital's fiscal year, as required by the Department, a hospital cost report for outpatient services which are subject to cost settlement in accordance with Regulation .11 of this chapter;

C. If an out-of-State or District of Columbia hospital, the special psychiatric hospital shall:

(1) Unless a waiver has been granted by the Secretary of Health and Human Services, have in effect a utilization review plan applicable to all participants who receive Medical Assistance under Title XVII of the Social Security Act which meets the requirements of §1861(k) of the Social Security Act; and

(2) Comply with applicable regulations of this chapter and COMAR 10.09.36.

.04 Covered Services.

A. The Program covers the following inpatient special psychiatric hospital services:

(1) Medically necessary services for the number of days, per admission, including days certified by the Department or its designee;

(2) Medically necessary mental health services authorized in accordance with COMAR 10.09.59.08 and as set forth in Regulation .05B(4) of this chapter;

(3) Medically necessary services when these services are:

(a) Necessary for the provision of diagnostic, curative, palliative, or rehabilitative treatment; and

(b) Described in the participant's medical record in sufficient detail to support the invoices submitted for services.

(4) Administrative days for the length of time certified by the Department or its designee;

(5) Leaves of absence for therapeutic reasons or extenuating circumstances up to 12 hours per day, if the participant returns the same day, before the census check; and

(6) Observation services.

B. The Program covers partial hospitalization when the hospital has:

(1) Written approval from the Office of Licensing and Certification Programs to be a provider of partial hospitalization in accordance with COMAR 10.21.02;

(2) A certificate of need from the Maryland Health Resources Planning Commission, if required, to be a provider of partial hospitalization; and

(3) Obtained preauthorization in accordance with COMAR 10.09.59.08.

.05 Limitations.

A. There are limitations placed on the coverage of some special psychiatric hospital inpatient and outpatient services.

B. The Program does not cover:

(1) Special psychiatric hospital services, procedures, drugs or admissions that are investigational or experimental;

(2) Services identified by the Department or its designee as not medically necessary;

(3) Elective inpatient admissions without preauthorization;

(4) Inpatient admissions or outpatient visits solely for the administration of injections, unless medical necessity and the participant's inability to take appropriate oral medications is documented in the participant's medical record;

(5) Inpatient mental health services for an individual between 21 and 64 in a special psychiatric hospital of more than 16 beds that primarily engages in providing mental health services for an individual who is not waiver-eligible, as defined in COMAR 10.09.62.01, except when receiving mental health services in the special psychiatric hospital immediately before the participant reached 21 years old, in which case the services may be continued until the earlier of the following:

(a) The date the participant no longer requires the services; or

(b) The date the participant reaches 22 years old;

(6) Outpatient visits for one or more of the following:

(a) Prescription drug or food supplement pick up;

(b) Collection of specimens for laboratory procedures;

(c) Recording of an electrocardiogram;

(d) Ascertaining the participant's weight; and

(e) Administration of vaccines;

(7) Leaves of absence beyond the period of the census check of the same day;

(8) Psychological evaluations and treatments except when:

(a) Ordered by a physician, and the medical necessity is documented in the participant's medical record; or

(b) Performed as mental health services as part of an approved treatment plan;

(9) Telephones, televisions, or personal comfort items or services;

(10) Duplicated care or service as indicated by more than one charge for the same stay or more than one room accommodation for the same time, for example, a charge for an inpatient day and observation room charge;

(11) Administrative days for participants pending discharge to home or nonmedical institutions;

(12) Inpatient and outpatient diagnostic and laboratory services not ordered by the attending physician or other practitioner;

(13) Inpatient days provided in excess of the days approved by the Department or its designee;

(14) Hospital laboratory tests which are coverable under COMAR 10.09.09, unless the specimen is obtained in the hospital;

(15) Admissions to special psychiatric hospitals, unless the participant is diagnosed with any one of the specialty mental health

codes listed in COMAR 10.09.70.02 or unless the Department or its designee grants a special exception based on the complexity of the situation at admission; or

(16) Elective admissions to hospitals outside of Maryland, except the District of Columbia, unless the Department or its designee determines that comparable services are not available in Maryland.

.06 Utilization Review Requirements.

A. Elective Inpatient Preauthorization Reviews.

(1) The special psychiatric hospital shall only request preauthorization for inpatient stays when such services:

(a) Cannot be provided on an outpatient basis; or

(b) Can only be provided in a facility that is licensed as a special psychiatric hospital.

(2) The special psychiatric hospital shall obtain preauthorization for elective inpatient admissions from the Department or its designee, before the participant is admitted, by providing the following information including, but not limited to:

(a) Participant's medical history and physical;

(b) Doctor's progress notes; and

(c) Sufficient clinical information or documentation that supports the medical necessity of the inpatient admission.

B. Concurrent Review Process.

(1) The concurrent review process shall be initiated by the hospital.

(2) If the participant remains hospitalized, additional days shall be certified by the Department or its designee before the termination of the previously certified days.

(3) The special psychiatric hospital shall forward sufficient clinical information or documentation to the Department or its designee that supports the need for continuing care. Information submitted shall include:

(a) Current health status;

(b) Treatment received to date;

(c) Proposed treatment plan for continued stay; and

(d) Discharge planning.

C. Retrospective Reviews.

(1) The special psychiatric hospital shall request that the Department or its designee perform a retrospective review of an inpatient admission after the participant is discharged, to determine the medical necessity of the admission.

(2) The special psychiatric hospital shall provide the following to the Department or its designee when requesting a retrospective review following discharge from a special psychiatric hospital. Documentation submitted shall include, but is not limited to:

(a) The participant's complete medical record;

(b) The principal, secondary, and tertiary diagnoses; and

(c) All relevant procedure codes.

D. Reviews for Nonqualified Aliens. The Department or its designee reviews the admission and discharge summary of an emergency inpatient admission for a nonqualified alien to determine whether the inpatient special psychiatric hospital stay meets the emergent condition criteria as defined in COMAR 10.09.24.05-2A.

.07 Payment Procedures.

A. Reimbursement Principles.

(1) The Department will make no direct reimbursement to any State-operated hospital. The Department will claim federal fund recoveries from the U.S. Department of Health and Human Services for services to participants in State-operated hospitals.

(2) The Department shall compare the current rates with the projected upper payment limit for inpatient days of service on or after July 1, 2012, in freestanding private psychiatric hospitals in Maryland whose rates for commercial providers are set by the HSCRC.

(3) If the rates do not exceed the projected upper payment limit calculated by the Department, the Department shall reimburse these hospitals using a rate of 94 percent of the current rates for services set by the HSCRC for each hospital's commercial providers in the fiscal year the prospective payments are made.

(4) If the rates do exceed the projected upper payment limit calculated by the Department, the per diem payments to each such hospital shall be decreased by the same proportion that the projected upper payment limit is exceeded.

(5) If the Program discontinues using rates which have been approved by HSCRC, the Program shall reimburse providers:

(a) According to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR §413; or

(b) On the basis of charges if less than reasonable cost.

(6) The Department may not reimburse for the services of a hospital's salaried or contractual physicians as a separate line item. When HSCRC has included these salaries in the hospital's costs, charges for these services shall be included in the room and board rate or the appropriate ancillary service only.

(7) Payment advances other than those made in accordance with HSCRC regulations may not be made routinely.

(8) Inpatient and outpatient services in out-of-State or District of Columbia special psychiatric and outpatient services in in-State special psychiatric hospitals are cost-settled on an annual basis according to §B of this regulation.

B. Retrospective Cost Reimbursement.

(1) Except as specified in §A of this regulation, a special psychiatric hospital not approved by the Program for reimbursement according to HSCRC rates shall be reimbursed:

(a) According to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR §413; or

(b) On the basis of charges, if less than reasonable cost.

(2) In calculating retrospective cost reimbursement rates, the Department or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, groups of costs, or costs of specific groups of participants. When the cost, or group or groups of costs designated, cover services rendered to all participants, including Medical Assistance participants, operating costs applicable to all participants shall be reduced by the amount of the restricted grants, gifts, or income from endowments thus resulting in a reduction of allowable costs.

(3) Final settlement for services in the provider's fiscal year shall be determined based on Medicare retrospective cost principles found at 42 CFR §413, adjusted for Medicaid allowable costs. Allowable costs specific to the Program shall be limited to a base-year cost per discharge increased by the applicable federal rate of increase times the number of Program discharges for that fiscal year.

(4) Base Year. For purposes of determining limits on the increase of cost, in accordance with Medicare regulations, the base year shall be:

(a) For an existing provider, the first year of entering into the Program or the first year separate rates for the unit or units of service or services are approved; and

(b) For a new provider, or all of these, the 12-month period immediately before the provider was initially subjected to target rate increases.

(5) Initial Interim Rates. In order to establish an initial interim rate, the provider shall submit to the Department or its designee, before the beginning of the first billing period, at least 90 days before the beginning of billing for services, the following:

(a) A detailed cost build-up, consistent with Medicare principles and cost finding, that supports the requested rate;

(b) A current, projected, and prior year's charge rate schedule;

(c) Finalized prior year's Medicare cost reports and the most current submission;

(d) A detailed revenue schedule; and

(e) Audited financial statements.

(6) The provider shall supply the Department or its designee the assurances necessary to establish that its customary charges to participants liable for payment on a charge basis exceed the allowable cost for these services.

(7) Initial Interim Rates for Newly Established Services or Providers.

(a) The provider shall submit to the Department or its designee, a detailed cost build-up, consistent with Medicare principles and cost finding, that supports the requested rate that follows Medicare principles and cost finding.

(b) The Department will compare the rate with a compatible facility and determine a reasonable rate that does not exceed the projected charges.

(8) Revision of Interim Rates.

(a) The provider may request an interim rate revision should the actual and projected cost exceed the interim rate by 10 percent.

(b) The provider shall furnish the Department or its designee with appropriate schedules showing the reason for the increase and other any other information that supports the rate increase.

(c) The Department will lower the provider's interim rate to approximate the final allowable reasonable cost based on the results of the prior year's review.

(d) The provider may request not more than two interim rate revisions during the accounting year.

(9) Cost Settlement.

(a) The provider shall submit to the Department or its designee:

(i) A Medicaid cost report based on actual data using the cost reporting forms used by Medicare for retrospective cost reimbursement;

(ii) A copy of the provider's Program log; and

(iii) A finalized Medicare cost report for the cost reporting year.

(b) The final Program cost report shall be sufficiently detailed to support a separate cost finding for Maryland Medical Assistance unique cost centers. The provider shall also submit a copy of its Maryland Medical Assistance log. The submitted cost report shall be in sufficient detail to support a separate cost finding for designated Maryland Medical Assistance unique cost centers.

(c) Tentative cost settlements may not be performed on a routine basis. However, the Program may, when it determines appropriate, calculate tentative settlements. The provider shall furnish the Department or its designee with a finalized Medicare cost report for the cost reporting year.

(d) The Department will base final settlement on the results of the finalized Medicare cost reports.

C. The Program shall reimburse room and board charges for the day of admission, but may not reimburse room and board charges for the day of discharge from the hospital.

D. The provider shall submit request for payment according to procedures established by the Department.

E. Payments on Medicare claims are authorized if:

(1) The provider accepts Medicare assignment;

(2) Medicare makes direct payment to the provider;

(3) Medicare determined the services were medically necessary;

(4) The services are covered by the Program; and

(5) Initial billing is made directly to Medicare according to Medicare guidelines.

F. Payment on Medicare claims is subject to the following provisions:

(1) Deductible and co-insurance, according to the limits of §E of this regulation, shall be paid subject to the HSCRC discounts, except in the case of a participant receiving hospital services in an out-of-State facility, in which case deductible and co-insurance shall be paid in full; or

(2) Services not covered by Medicare, but by the Program, if medically justified according to §E of this regulation.

G. Administrative Days.

(1) To be paid for administrative days, the special psychiatric hospital shall document, on forms designated by the Department, information demonstrating that the participant who was initially eligible has been determined to no longer require special psychiatric hospital services and the provider has:

(a) Received a determination from the Department or its designee that the participant requires the level of service provided in a lower-acuity facility, but an appropriate facility is not available;

(b) Established a plan for discharge during the period of administrative days, is actively pursuing placement at an appropriate level of care for the participant, and has documented this activity in the participant's record;

(c) Maintained documentation in the participant's medical record that placement activity was conducted no fewer than 3 days per week during the period for which payment is requested for administrative days; and

(d) Notified the local agency responsible for development of the discharge treatment and education plan of the potential placement, if the participant is at risk of a residential treatment center placement on admission;

(2) If the participant requires the level of care provided by a residential treatment center and a bed in a residential treatment center is not available, in order to be paid for administrative days, the special psychiatric hospital shall document that it timely notified local coordinating councils and any other local agency, as appropriate, of the necessity to continue inpatient psychiatric service at a residential treatment center before the termination of the need for inpatient psychiatric hospitalization;

(3) If the participant is at an inappropriate level of care but cannot be moved, in order to be paid for administrative days, the special psychiatric hospital shall:

(a) Provide the attending physician's declaration that, because of physical or emotional problems, the participant is unable to be moved;

(b) Document in the participant's medical record the attending physician's reasons why the participant cannot be moved; and

(c) Document the attending physician's reevaluation of the participant's inability to be moved in the participant's record at least every 14 days in special psychiatric hospital.

H. Payment for approved administrative days for a special psychiatric hospital seeking placement of a participant to a residential treatment center shall be the average residential treatment center rate issued pursuant to COMAR 10.09.29.13B.

I. The Department may not reimburse a special psychiatric hospital for administrative days if:

(1) The special psychiatric hospital bills the Program for days of care for which the hospital is licensed to provide; or

(2) The Program or the Program's designee determines the participant no longer requires the level of care for the days requested.

J. The Department may not make direct payment to the participant.

K. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.06.

L. The Department reserves the right to return to the provider, before payment, all invoices not properly completed.

M. Noncompliance with the Program's requirements as determined by the Department or its designee shall result in nonpayment of the claim.

.08 Recovery and Reimbursement.

A. General policies governing recovery and reimbursement procedures applicable to all providers are set forth in COMAR 10.09.36.07.

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

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

Causes for suspension or removal and imposition of sanctions shall be as set forth in COMAR 10.09.36.08.

.10 Appeal Procedures.

A provider filing an appeal from an administrative decision made in connection with these regulations shall do so according to COMAR 10.09.36.09.

.11 Submitting Cost Reports.

A. The provider shall submit to the Department or its designee, in the form prescribed, financial and statistical data within 5 months after the end of the provider's fiscal year unless the Department grants the provider an extension or the provider discontinues participation in the Program.

B. For hospitals who do not submit reports within 5 months, for whom an extension has not been granted, and who are reimbursed according to Medicare standards and principles for retrospective cost reimbursement as described in 42 CFR §413, the Department shall:

(1) Withhold from the provider a maximum of 5 percent of the current monthly interim payment starting the calendar month after the calendar month in which the report is due and any subsequent calendar months until the report has been submitted; and

(2) Refund withholdings at cost settlement.

C. If a provider discontinues participation, financial and statistical data shall be submitted to the Department within 45 days after the effective date of termination.

D. The Program shall grant an extension for submission of cost reports:

(1) Upon written request by the provider, setting forth the specific reasons for the request, if the Department determines, taking into consideration the totality of the circumstances, that the request is reasonable; or

(2) Concurrent with any extension granted to the special psychiatric hospital by Medicare, but not to exceed 60 days from the due date of cost reports.

E. In addition to a reduction in payment percentage or withholding a percentage of interim payment pursuant to §B of this regulation, when a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year and the provider has not received an extension, the Department may impose one or more sanctions as provided for in Regulation .09 of this chapter.

F. When a report is not submitted by the last day of the 6th month after the end of the provider's fiscal year or a report is submitted but the provider cannot furnish proper documentation to verify costs, the Department shall, if applicable, make final cost settlement for that fiscal year at a certain percentage of the last final per diem rates for which the Department has verified costs for that facility, provided that the rates established will not exceed the maximum per diem rates in effect when the facility's costs were last settled.

G. For purposes of §§A—F of this regulation, reports are considered received when the submitted reports are completed according to instructions issued by the Department or its designee.

.12 Cost Settlement.

A. The Department or its designee shall notify each provider participating in the Program of the results of the final settlement under Regulation .07 of this chapter.

B. Within 60 days after the provider receives the notification described in §A of this regulation, the Department shall pay the amount due to the provider regardless of whether the provider files an appeal.

C. The provider may request review of the settlement under Regulation .07 of this chapter by filing written notice with the Program's Appeal Board within 30 days after receipt of the notification of the results of the settlement from the Department or its designee.

D. The Appeal Board shall be composed of the following:

(1) A representative of the hospital industry who is:

(a) Knowledgeable in Medicare and Medicaid reimbursement principles; and

(b) Appointed by the Secretary of the Department;

(2) An individual who:

(a) Is employed by the State;

(b) Is knowledgeable in Medicare and Medicaid reimbursement principles;

(c) Did not participate in the verification of costs; and

(d) Is appointed by the Secretary of the Department; and

(3) A third member selected by the first two members of the Appeal Board.

E. When the Appeal Board reviews an appeal from a provider in which an Appeal Board member is employed or in which the member has a financial or personal interest, the Secretary of the Department shall designate an alternate for the member.

F. If the provider elects not to appeal to the Appeal Board, the provider shall:

(1) Pay the amount due within 60 days after the notification described in §A of this regulation; or

(2) Request a longer payment schedule within 60 days after the provider receives notification of the amount due to the Program.

G. After consultation with the provider, the Department may establish a longer payment schedule if it determines, based on sufficient documentation submitted by the provider, that failure to grant a longer payment schedule would:

(1) Result in financial hardship to the provider; or

(2) Have an adverse effect on the quality of participant care furnished by the facility.

H. If the provider elects to appeal to the Appeal Board, the following provisions apply:

(1) Within 30 days after the filing of an appeal by a provider that the Department or its designee determined owes money to the Program, the Department or its designee shall:

(a) Recalculate the amount due to the Program based on the verification, exclusive of the amount in controversy which is subject to the appeal; and

(b) Notify the provider of that amount;

(2) In order to enable the Department or its designee to perform this recalculation, the provider shall indicate the specific adjustment and the specific amount being appealed;

(3) Subject to the provisions of §H(4) of this regulation, payment for the amount due the Program, if any, after the recalculation, shall be made within 60 days after the provider receives notification of the recalculation; and

(4) If a provider requests a longer payment schedule within 60 days after the provider receives notification of the recalculation, the

Department may establish, after consultation with the provider, a longer payment schedule in accordance with §G of this regulation.

I. Appeal Board Findings.

(1) After the Department receives the findings of the Appeal Board, the Department shall:

(a) Determine the amount that is due either to the Program or to the provider; and

(b) Notify the provider of that amount.

(2) The portion of the amount in controversy that is paid is subject to an award of interest that is:

(a) Calculated from the date the appeal was filed through the date of payment; and

(b) Based on the 6-month Treasury Bill rate in effect on the date the appeal was filed.

(3) Interest paid to a provider under §I(2) of this regulation is not subject to any offset or other reduction against otherwise allowable costs.

(4) If the provider accepted the determination made under §I(1) of this regulation, within 60 days after the provider receives the notification under §I(1) of this regulation, the Program shall pay the amount the Department determined is due the provider, if any.

(5) Subject to §I(6) of this regulation, within 60 days after the provider receives the notification, the provider shall pay the amount due the Program, if any.

(6) If a provider requests a longer payment schedule within 30 days after the provider receives notification of the amount due the Program, the Department may establish, after consultation with the provider, a longer payment schedule in accordance with §G of this regulation.

J. After expiration of the 60-day payment period, or longer payment schedule established by the Department as described in §§F—I of this regulation, and in addition to the sanctions provided in Regulation .09 of this chapter, the Department may recover the unpaid balance by withholding the amount due from the interim payment which would otherwise be payable to the provider.

K. The Department or a provider aggrieved by a reimbursement decision of the Appeal Board may appeal the Appeal Board's decision as the final agency decision under the Administrative Procedure Act, State Government Article, §10-222, Annotated Code of Maryland.

L. If the provider or the Department appeals a final decision of the Appeal Board, the provider or the Department shall place any money due from the provider or from the Program in an interest-bearing escrow account. The money due shall include the interest, based on the rate in §I(2)(b) of this regulation, calculated from the date of the administrative appeal through the date of opening the escrow account. The money shall remain in escrow until a final decision has been rendered. Upon a final determination of the dispute, the appropriate person administering the escrow account shall distribute the money in that account, including any interest accrued, in conformity with the final determination.

M. The provider may file an appeal of the results of the settlement with the Medicare Appeal Board as a substitute for the Department's Appeal Board, and the decision rendered by the Medicare Appeal Board will be accepted by the Department as binding.

.13 Interpretive Regulation.

General policies governing the interpretive regulations applicable to all providers are set forth in COMAR 10.09.36.10.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[16-333-P]

The Secretary of Health and Mental Hygiene proposes to amend:

(1) Regulation **.04** under **COMAR 10.09.08 Freestanding Clinics**; and

(2) Regulations **.04** and **.06** under **COMAR 10.09.77 Urgent Care Centers**.

Statement of Purpose

The purpose of this action is to clarify language regarding scope of practice for services rendered by physicians, nurses, psychologists, and social workers in freestanding clinics and by physicians and physician assistants in urgent care centers.

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 January 23, 2017. A public hearing has not been scheduled.

10.09.08 Freestanding Clinics

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

.04 Covered Services.

A. (text unchanged)

B. Medically Necessary Services. The program covers medically necessary services as described in §§C, D, and E of this regulation and in Regulation .05 of this chapter, rendered to participants by a freestanding clinic, when these services are performed by a physician or by **[**one of the following**]**:

(1) A registered nurse, *a* psychologist, or a social worker, provided that the individual**[**:

(a) Performing the service is in the physician's employ;

(b) Is under the physician's direct supervision; and

(c) Performs**]** *performs* the service within the scope of the individual's license or certification for the purpose of assisting in the provision of physicians' services;

(2)—(3) (text unchanged)

C.—E. (text unchanged)

10.09.77 Urgent Care Centers

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

.04 Covered Services.

The Program covers the following medically necessary services rendered to recipients in a free-standing urgent care center:

A.—C. (text unchanged)

D. **[**Physician**]** *Urgent care* services **[**rendered in free-standing urgent care centers**]**, when the services are performed by a physician or one of the following *acting within the scope of their practice*:

[(1) Another licensed physician in the physician's employ;**]**

[(2)**]** *(1)* A certified registered **[**physician's**]** *physician* assistant **[**or a**]***;*

(2) A licensed registered nurse **[**provided the individual performing the service:**]***; or*

[(a) Is in the physician's employ;

(b) Is under the physician's direct supervision; and

(c) Performs the service within the scope of the individual's license or certification for the purpose of assisting in the provision of physician's services; or**]**

(3) A certified nurse practitioner **[**provided that the individual performing the service is in the physician's employ and performs the services within the scope of the individual's license or certification**]**; and

E. (text unchanged)

.06 Payment Procedures.

A. Payment for free-standing urgent care centers is as follows:

(1) (text unchanged)

(2) In addition to the facility fee, the Program shall reimburse for services rendered by the physician, *nurse practitioner, or physician assistant* during the visit at the free-standing urgent care center **[**when performed by a physician, or by other authorized personnel under that physician's supervision**]**; and

(3) (text unchanged)

B.—J. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.24 Medical Assistance Eligibility

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

Notice of Proposed Action

[16-355-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.08-2** under **COMAR 10.09.24 Medical Assistance Eligibility**.

Statement of Purpose

The purpose of this action is to codify informal rules that comport with the business of operating pooled special needs trusts and of drafting stand-alone Special Needs Trusts.

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 A. Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. 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 January 23, 2017. A public hearing has not been scheduled.

.08-2 Treatment of Trust Amounts.

A. (text unchanged)

B. Treatment of Trusts Established after August 10, 1993.

(1)—(6) (text unchanged)

(7) A nonprofit association that establishes and manages a trust consistent with the requirements of §B(6)(b) of this regulation may establish accounts for individuals for whom no governmental entity has made a determination of disability, provided that:

(a) The beneficiary of the account has submitted, or is actively engaged in preparing to submit, an application to:

(i) The Social Security Administration for Supplemental Security Income or Social Security Disability Insurance; or

(ii) The Department of Human Resources State Review Team for a disability determination using the Social Security Administration rules; and

(b) The account is closed immediately upon a determination, exclusive of appeals, by any State or federal governmental agency that the beneficiary of the account is not disabled.

C. Special Needs Trust. The following criteria shall define a single, stand-alone special needs trust that is funded with assets that belonged to the beneficiary:

(1)—(5) (text unchanged)

(6) The trust provides that all **[**States**]** *states* which have provided medical assistance benefits to the beneficiary shall be paid their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all **[**States**]** *states*, up to the amount of assets remaining in the trust upon the death of the beneficiary;

(7) If the trust allows for the termination of the trust before the death of the beneficiary, the trust shall provide that:

(a) All **[**States**]** *states* which have provided medical assistance benefits to the beneficiary shall be paid their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all **[**States**]** *states*, up to the amount of assets remaining in the trust at the time of termination, after administrative expenses related to the termination of the trust;

(b) Other than amounts paid to the **[**States**]** *states* under §C(7)(a) of this regulation and payment of administrative expenses and reasonable compensation to the trustee for trust management, along with reasonable costs associated with investment, legal, or other services, no entity other than the trust beneficiary may benefit from early termination of the trust; and

(c) (text unchanged)

(8) The trust does not permit distribution of trust assets upon termination of the trust that would hinder or delay reimbursement to the **[**Department**]** *states* under §C(6) and (7) of this regulation;

(9) The trust does not place time limits, or any other limits, on the **[**States'**]** *states'* claim for reimbursement under §C(6) and (7) of this regulation;

(10) The trust contains the following provisions:

(a)—(c) (text unchanged)

(d) The trustee shall administer the trust in accordance with the provisions of Estates and Trusts Article, §15-502, Annotated Code of Maryland, and may not:

(i) **[**Have**]** *Except for the beneficiary's relative, limited to the relatives defined at COMAR 10.09.24.02B(10)(a), who may have a contingent future interest in any trust funds remaining in the trust after the requirements of §C(6) of this regulation have been met, have* an interest in trust assets;

(ii)—(iv) (text unchanged)

(e)—(m) (text unchanged)

(n) Trust assets may not be used to purchase an annuity on the life of the beneficiary unless, upon the beneficiary's death, all **[**States**]** *states* which have provided medical assistance benefits to the beneficiary are paid, out of any remaining annuity payments, their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all **[**States**]** *states*.

(o)—(t) (text unchanged)

(u) The trust may not receive payments from a structured settlement or an annuity that was purchased by funds that are not part of the trust unless:

(i) Upon the beneficiary's death, all **[**States**]** *states* which have provided medical assistance benefits to the beneficiary are paid, out of any remaining annuity or settlement payments, their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all **[**States**]** *states*; and

(ii) (text unchanged)

(11)—(12) (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[16-335-P]

The Secretary of Health and Mental Hygiene proposes to:

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

(2) Amend Regulation **.28** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**;

(3) Repeal in their entirety Regulations **.01 —.03** under **COMAR 10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers**; and

(4) Adopt new Regulations **.01—.11** under a new chapter, **COMAR 10.09.76 School-Based Health Centers**.

Statement of Purpose

The purpose of this action is to establish a single chapter of regulations for both fee-for-service and MCO school-based health center providers and to update references to the new chapter.

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 A. Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. 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 January 23, 2017. A public hearing has not been scheduled.

10.09.62 Maryland Medicaid Managed Care Program: Definitions

Authority: Health-General Article, §15-101, Annotated Code of Maryland

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1)—(157) (text unchanged)

(158) "School-based health center (SBHC)" means a provider located on school grounds that meets the requirements set forth in COMAR **[**10.09.68**]** *10.09.76*.

(159)—(181) (text unchanged)

10.09.67 Maryland Medicaid Managed Care Program: Benefits

Authority: Health-General Article, §15-103(b)(1), Annotated Code of Maryland

.28 Benefits — Self-Referral Services.

A. An MCO shall be financially responsible for reimbursing, in accordance with COMAR 10.09.65.20, an out-of-plan provider chosen by the participant for the following services:

[A.**]** *(1)* (text unchanged)

[B.**]** *(2)* Services performed by school-based health centers *(SBHCs)*, as provided in COMAR **[**10.09.68**]** *10.09.76*;

[C.**]** *(3)*—**[**I.**]** *(9)* (text unchanged)

B. An MCO shall pay undisputed claims of the SBHC for services provided to its participants within 30 days of the MCO's receipt of the invoice.

C. An MCO shall provide SBHCs in its service area with the current information needed to facilitate communication between the SBHC, PCP, and the MCO regarding care provided to the MCO's participant, and to effect reimbursement by the MCO, including:

(1) Information concerning the MCO's policies and procedures regarding the provision of pharmacy and laboratory services;

(2) Instructions for submitting claims; and

(3) Contact information, including names and phone numbers of the following individuals:

(a) The MCO representative who serves as an SBHC's contact person for coordination of care; and

(b) The student-participant's PCP.

10.09.76 School-Based Health Centers (SBHC)

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

.01 Definitions.

A. The following terms have the meanings indicated.

B. Terms Defined.

(1) "Department" means the Maryland Department of Health and Mental Hygiene, the State agency designated to administer the Maryland Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

(2) "Early and periodic screening, diagnosis and treatment (EPSDT)" means the provision of preventive health care, including medical and dental services under 42 CFR §441.50 et seq., in order to assess growth and development and to detect and treat health problems in Medical Assistance eligible individuals younger than 21 years old.

(3) "Federally qualified health center (FQHC)" means an entity that has entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to meet Medicare requirements under 42 CFR §405.2464 and in accordance with 42 CFR §405.2401(b).

(4) "Managed care organization (MCO)" has the meaning stated in Health-General Article, §15-101, Annotated Code of Maryland.

(5) "Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventive, curative, palliative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with currently accepted standards of good medical practice, dental practice, or both;

(c) The most cost efficient that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the participant, family, or provider.

(6) "Medicare" means the insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

(7) "Participant" means an individual who is certified as eligible for, and who is receiving, Medical Assistance benefits.

(8) "Primary care provider (PCP)" means a practitioner who is the primary coordinator of care for the participant, and whose responsibility it is to provide accessible, continuous, comprehensive, and coordinated health care services covering the full range of benefits required by the Maryland Medical Assistance Program.

(9) "Primary health services" means a basic level of health care, including diagnostic, treatment, consultative, referral, and preventive health services, generally rendered by:

(a) General practitioners;

(b) Family practitioners;

(c) Internists;

(d) Obstetricians;

(e) Gynecologists;

(f) Pediatricians; and

(g) Midlevel practitioners, such as physician assistants and nurse practitioners.

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

(11) "Provider" means a school-based health center which has been approved by the Department.

(12) "School-based health center (SBHC)" means a health center that:

(a) Is located on school grounds;

(b) Provides on-site primary and preventive health care, referrals, and follow-up services;

(c) Could provide on-site dental care or behavioral health care, referrals, and follow-up services; and

(d) Has been approved by the Maryland State Department of Education (MSDE).

(13) "Specialty behavioral health" means services specified in COMAR 10.09.59.06 and 10.09.80.05.

.02 License Requirements.

A. The provider shall meet all license requirements as set forth in COMAR 10.09.36.02.

B. A physician, nurse practitioner, or physician assistant providing services in an SBHC shall be licensed and legally authorized to practice medicine in the state in which the service is provided.

C. A dentist or dental hygienist providing services in an SBHC shall be licensed and legally authorized to practice in the state in which the service is provided.

.03 Conditions for Participation.

A. General requirements for participation in the Program are that a provider shall meet the:

(1) Conditions for participation as set forth in COMAR 10.09.36.03; and

(2) General requirements for participation as a free-standing clinic as set forth in COMAR 10.09.08.03B.

B. Specific requirements for participation in the Program as an SBHC are that a provider shall:

(1) Be approved by the Maryland State Department of Education (MSDE) as an SBHC;

(2) Have a written agreement with one of the following enrolled sponsoring agencies:

(a) Local health department as defined in 45 CFR §164.501 (Public Health);

(b) Federally qualified health center as defined in 42 CFR § 405.2400(b); or

(c) General clinic as defined in 42 CFR §440.90;

(3) Provide somatic health care services through health professionals who:

(a) Are trained and experienced in community health and providing health care services to school-aged children;

(b) Have knowledge of health promotion and illness prevention strategies for children and adolescents; and

(c) Are EPSDT certified;

(4) Ensure staff is assigned responsibilities consistent with the staff's education and experience and within the staff's scope of practice;

(5) Designate an individual to be responsible for overall management of the SBHC;

(6) Whenever comprehensive primary health services are being delivered, maintain a staffing pattern that includes at least one of the following on-site:

(a) A physician;

(b) A nurse practitioner; or

(c) A physician assistant;

(7) Maintain policies and procedures that ensure confidentiality of services and records which are practiced consistently, in accordance with Health-General Article, §4-301, Annotated Code of Maryland;

(8) Maintain data collection and storage capabilities adequate to maintain medical records and standard demographic data;

(9) Require any physician assistant employed by the provider to have a delegation agreement with the supervising physician in accordance with COMAR 10.09.55.02 and .03; and

(10) Transmit a health visit report:

(a) To the student's MCO and PCP within 3 business days of the health visit, as designated by the Department, for inclusion in the student-participant's medical record; and

(b) If follow-up care with the PCP within 1 week of the health visit is required and the health visit report is mailed, to the student's MCO and PCP by telephone, email, or fax on the day of the SBHC visit.

C. Specific requirements for participation in the Program as a dentist or dental hygienist in an SBHC are that a provider shall meet the conditions for participation as set forth in COMAR 10.09.05.03A—E.

.04 Covered Services.

An SBHC, designated by the Department as meeting the criteria specified in Regulation .03 of this chapter, is eligible for reimbursement by the Program for the following services:

A. Comprehensive well-child care, including the administration of vaccines in accordance with the Maryland Healthy Kids Preventive Health Schedule, when:

(1) Performed by EPSDT certified providers; and

(2) Rendered according to EPSDT standards set forth in COMAR 10.09.23.03;

B. Follow-up of positive or abnormal EPSDT screening components without approval of the PCP, except when referral for specialty care is indicated;

C. Comprehensive preventive and primary health services;

D. Family planning services as described in COMAR 10.09.58.05;

E. Covered dental services in accordance with COMAR 10.09.05.04A(1)—(3), (5), (7), (9) and C(1)(e) and (2); and

F. Specialty behavioral health in accordance with COMAR 10.09.59.06 and 10.09.80.05.

.05 Limitations.

The Program does not cover the following:

A. Services not specified in Regulation .04 of this chapter;

B. Services not medically necessary;

C. Investigational and experimental drugs and procedures;

D. Basic school health services as defined in COMAR 13A.05.05.05—.15;

E. Services to individuals who are not enrolled in the school system;

F. Nursing or other health services provided as part of a participant's individualized educational program (IEP) as defined in COMAR 10.09.50.01B or individualized family service plan (IFSP) as defined in COMAR 10.09.50.01B;

G. Skilled nursing services provided to enable a participant to be safely maintained in the school setting such as:

(1) Nasogastric tube feedings;

(2) Catheterization;

(3) Oral, nasotracheal, or tracheal suctioning; and

(4) Nebulizer treatments;

H. School health services which are required in all school settings such as:

(1) Hearing and vision screening unless completed as part of an EPSDT well-child check-up;

(2) Routine assessment of minor injuries;

(3) First aid;

(4) Administration of medications including supervision of self-administered medications;

(5) General health promotion counseling; and

(6) Review of health records;

I. Routine sports physicals;

J. Vaccines supplied by Vaccines for Children (VFC);

K. Visits for the sole purpose of:

(1) Administering medication;

(2) Checking blood pressure;

(3) Measuring weight;

(4) Interpreting lab results; or

(5) Group or individual health education; and

L. Services provided outside of the physical location of the approved SBHC.

.06 Reimbursement Methodology.

A. The provider shall charge the Program the provider's customary charge to the general public for similar services and charge the provider's acquisition cost for injectable drugs or dispensed medical supplies.

B. If the service is free to individuals not covered by Medicaid:

(1) The provider:

(a) May charge the Program; and

(b) Shall be reimbursed in accordance with §B of this regulation; and

(2) The provider's reimbursement is not limited to the provider's customary charge.

C. Local health department clinics or general clinics shall be paid the lesser of:

(1) The provider's customary charge to the general public unless the service is free to individuals not covered by Medicaid;

(2) The maximum rates according to COMAR 10.09.02.07; or

(3) In the case of specialty behavioral health services, in accordance with COMAR 10.21.25.

D. The Department shall reimburse an SBHC, sponsored by an FQHC, for somatic services in accordance with COMAR 10.09.08.08.

E. The Department shall reimburse an SBHC, sponsored by an FQHC, for dental services at an all-inclusive, per-visit cost-based rate that has been established in accordance with COMAR 10.09.08.08.

F. The Department shall reimburse an SBHC, sponsored by an LHD, for dental services in accordance COMAR 10.09.05.07.

.07 Payment Procedures.

A. The provider shall submit a completed request for payment in the format designated by the Department or HealthChoice MCO, including required documentation.

B. The dental provider shall submit a request for payment in the format designated by the Department and in accordance with COMAR 10.09.05.07.

C. The Program reserves the right to return to the provider, before payment, all invoices not properly completed.

D. Unless the service is free to individuals not covered by Medicaid, a provider shall bill the Program the provider's customary charge to the general public for similar services.

E. The Department shall authorize payment on Medicare cross-over claims only if:

(1) The provider accepts Medicare assignments;

(2) Medicare makes a direct payment to the provider;

(3) Medicare determines the services are medically necessary;

(4) The services are covered by the Program; and

(5) Initial billing is made directly to Medicare according to Medicare guidelines.

F. The Department shall make supplemental payment on Medicare cross-over claims subject to the following provisions:

(1) A deductible shall be paid in full;

(2) Coinsurance shall be paid at the lesser of:

(a) 100 percent of the coinsurance amount; or

(b) The balance remaining after the Medicare payment is subtracted from the Medicaid rate;

(3) Services not covered by Medicare, but considered medically necessary by the Program, shall be paid according to the limitations of this chapter; and

(4) Coinsurance shall be paid in full to FQHC providers.

G. An SBHC providing self–referred services as described in COMAR 10.09.67.28 to an MCO participant shall:

(1) Verify eligibility and MCO assignment through EVS on the day of service;

(2) Submit claims within 180 days of performing the service;

(3) Submit claims using the CMS 1500 for paper processing and the HIPAA compliant 837P for electronic processing; and

(4) Bill third party insurers before billing the MCO with the exception of well-child care and immunizations.

H. The provider may not bill the Program for:

(1) Completion of forms and reports;

(2) Broken or missed appointments;

(3) More than one visit to complete an EPSDT screen; and

(4) Providing a copy of a participant's medical record when requested by another licensed provider on behalf of the participant.

I. The Program may not make direct payment to participants.

J. The Program may not make a separate direct payment to any individual employed by or under contract to any SBHC for services provided in an SBHC.

K. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.

.08 Recovery and Reimbursement.

Recovery and reimbursement are as set forth in COMAR 10.09.36.07.

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

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

.10 Appeal Procedures.

Providers filing appeals from administrative decisions made in connection with this chapter shall do so according to COMAR 10.09.36.09.

.11 Interpretive Regulation.

State regulations shall be interpreted in conformity with COMAR 10.09.36.10.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 29 BOARD OF MORTICIANS AND FUNERAL DIRECTORS

10.29.09 Requirements for Apprenticeship

Authority: Health Occupations Article, §§*7–101*, 7-205, 7-305, and 7-306, Annotated Code of Maryland

Notice of Proposed Action

[16-345-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.02—.06**, **.11**, and **.14** under **COMAR 10.29.09 Requirements for Apprenticeship**. This action was considered at a public meeting on October 12, 2016, notice of which was given by publication on the Board's website at http://dhmh.maryland.gov/bom/Pages/home.aspx pursuant to General Provisions Article, §3–302(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to:

(1) Define certain terms;

(2) Provide that an apprentice sponsor shall meet certain qualifications in order to be approved as an apprentice sponsor;

(3) Clarify that the apprentice's sponsor may delegate supervision to another licensed mortician or funeral director and that the sponsor assumes full responsibility on their license for the delegate or apprentice sponsor's conduct;

(4) Revise the list of practical experiences required for an applicant for a license as a funeral director to complete;

(5) Revise the list of practical experiences required for an applicant for a license as a mortician to complete;

(6) Revise the documentation required to show completion of the requirements of an apprenticeship;

(7) Increase the clinical embalming assists from 20 to 25 for individuals studying to be a mortician;

(8) Limit the number of sponsors an apprentice shall have and require that each sponsor attest to the Board what each sponsor is responsible for teaching the apprentice;

(9) Revise the apprentice licensure requirements;

(10) Provide that an apprentice may participate in making funeral arrangements with the sponsor or sponsor's delegate but may not make funeral arrangements, including pre-need arrangements, unless the apprentice is under the direct supervision of the sponsor or sponsor's delegate; and

(11) Clarify that an apprentice may not sign a funeral establishment contract.

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 January 23, 2017. A public hearing has not been scheduled.

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) "Apprentice sponsor" means a mortician or funeral director who:

(a) Has **[**completed at least 20 services or embalmings**]** *been in good standing with the Board for the previous 5 years*;

(b) Has been practicing mortuary science as a licensed mortician or funeral director in Maryland at least **[**1 year**]** *5 years* immediately before accepting the apprentice;

(c) Manages, owns, or is employed **[**in one or more**]** *by a* licensed funeral **[**establishments**]** *establishment* in Maryland *in which the licensed apprentice is employed*; **[**and**]**

(d) **[**May be employed by the sponsor or delegated by the sponsor to provide instruction to the sponsor's apprentice**]** *Is responsible for the direct supervision of 1,000 hours of work with the apprentice; and*

(e) Assumes responsibility on their individual license for the delegate or apprentice's conduct, whether it is consistent or fails to be consistent with the professional standards and provisions set forth in Health Occupations Article, Title 7, Annotated Code of Maryland.

(3)—(4) (text unchanged)

(5) "Delegate" means a licensed mortician or a licensed funeral director employed by the same licensed funeral establishment as the apprentice sponsor and to whom the apprentice sponsor delegates direct supervision.

(6) "Direct supervision" has the same meaning as in Health Occupations Article, §7-306(e)(3), Annotated Code of Maryland.

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

[(6)**]** *(8)* "Licensed apprentice" means an apprentice who is licensed by the Board to assist **[**a licensed mortician or funeral director in the practice of mortuary science**]** *the apprentice sponsor or a licensee delegated by the sponsor to provide direct supervision*.

[(7)**]** *(9)*—**[**(8)**]** *(10)* (text unchanged)

.03 Requirements of Apprenticeship [— Funeral Service Arrangement].

A. To meet the apprentice requirements set forth in Health Occupations Article, §7-306, Annotated Code of Maryland, an applicant for a mortician's or funeral director's license shall be employed in the same Maryland establishment as the applicant's sponsor *or the sponsor's delegate* and serve under the direct supervision of the applicant's sponsor *or the sponsor's delegate*.

B. (text unchanged)

C. Applicants shall obtain practical experience in funeral service arrangements **[**consisting of**]**, *including*:

[(1) Assisting the mortician or funeral director in:

(a) Preparing a car list;

(b) Seating arrangements;

(c) Counseling the family; and

(d) The use and care of physical equipment;

(2) Handling floral pieces, including:

(a) Receipt and proper arrangement;

(b) The proper listing of senders and kinds of flowers; and

(c) The proper care of floral pieces at the cemetery;

(3) Securing necessary certificates from physicians and medical examiners, and records incident to disposition;

(4) Removing the deceased to the funeral establishment;

(5) Making clothing arrangements;

(6) Assisting in the selection of the following:

(a) Casket;

(b) Outer burial container; or

(c) Urn;

(7) Assisting in the arrangement of the interment;

(8) Arranging military or fraternal organization services; and

(9) Assisting in the arrangement of a cremation, including filling out and securing proper signatures on the:

(a) Authorization for Cremation form; and

(b) Identification form.**]**

(1) 20 funeral directions and at least one of each of the following:

(a) A pre-need arrangement;

(b) An at-need arrangement for burial;

(c) A cremation arrangement; and

(d) A cemetery transfer with a service; and

(2) 1,000 hours worked under the direct supervision of the apprentice sponsor or the sponsor's delegate.

D. An applicant for a mortician's license shall obtain practical experience in funeral service arrangements consisting of:

(1) Participation in the activities outlined in §C of this regulation; and

(2) 25 embalmings under the direct supervision of the sponsor or the sponsor's delegate.

.04 Documentation.

A. An apprentice shall submit documentation to the Board of completion of the following requirements to be considered for a mortician's license:

(1) (text unchanged)

(2) On the mortician application form provided by the Board, evidence of participation in:

(a) **[**20**]** *25* embalming assists with corresponding copies of the filed death certificates for the embalmed human remains; and

(b) **[**20**]** *24* funeral *direction* assists, *as specified in Regulation .03C(1) of this chapter,* with a corresponding published notice of the service for each of the *at least* **[**20**]** *24* decedents *and a copy of the filed death certificate*;

(3) A notarized statement signed by the apprentice and the apprentice sponsor verifying the completion of 1,000 hours worked under the direct supervision of the apprentice sponsor; **[**and**]**

(4) Embalming reports signed by the apprentice and apprentice sponsor to document the apprentice's participation in **[**20**]** *25* embalmings*; and*

(5) Documentation on a form provided by the Board and signed by the apprentice and apprentice sponsor or the sponsor's delegate of participation in:

(a) A pre-need arrangement;

(b) An at-need arrangement for burial;

(c) A cremation arrangement; and

(d) A cemetery transfer with a service.

B. An apprentice shall submit documentation to the Board of completion of the following requirements to be considered for a funeral director's license:

(1)—(2) (text unchanged)

(3) A notarized statement signed by the apprentice and the apprentice sponsor verifying the completion of*:*

(a) 20 funeral directions and at least one of each of the following:

(i) A pre-need arrangement;

(ii) An at-need arrangement for burial;

(iii) A cremation arrangement; and

(iv) A cemetery transfer with a service; and

(b) 1,000 hours worked under the direct supervision of the apprentice sponsor *or sponsor's delegate*.

.05 Embalming Requirements for Mortuary Science Apprenticeship.

[A. Applicants for an apprenticeship who are studying to be a mortician shall obtain experience in the embalming of dead human bodies which includes training in:

(1) Theoretical and practical aspects of the following:

(a) Anatomy;

(b) Sanitation;

(c) Disinfection; and

(d) Embalming;

(2) Methods for the care and preparation of dead human bodies for final disposition; and

(3) The laws and regulations on infectious diseases.

B. An apprentice shall submit documentation signed by the sponsor on the form required by the Board of the apprentice's participation in at least 20 embalmings.**]**

[C.**]** *A.* If the apprentice sponsor has more than one apprentice, unless otherwise approved by the Board, only one apprentice may receive credit on the same **[**body**]** *human remains* if more than one apprentice assisted the apprentice sponsor.

[D.**]** *B.* (text unchanged)

.06 Commencement of Apprenticeship.

A. The apprentice and the apprentice sponsor *or sponsors* shall appear before the Board and receive the Board's approval of the apprenticeship before the apprenticeship commences.

B. (text unchanged)

[C. The apprentice sponsor shall submit proof of completion of 20 embalmings or services**]**

C. The apprentice may have no more than two sponsors who shall attest to the Board what each sponsor is responsible for teaching the apprentice.

D. The apprentice sponsor shall assume responsibility on their individual license for the delegate or apprentice's conduct, whether it is consistent or fails to be consistent with the professional standards

and provisions set forth in Health Occupations Article, Title 7, Annotated Code of Maryland.

.11 General Requirements.

A.—D. (text unchanged)

E. The applicant shall:

(1) Apply for apprenticeship on the form required by the Board; *and*

(2) Pay the fee as specified in COMAR 10.29.04**[**; and

(3) Be of good moral character and may not have committed any of the grounds for discipline specified in Health Occupations Article, §7-316, Annotated Code of Maryland**]**.

.14 Prohibitions.

A. (text unchanged)

B. An apprentice may *participate in making funeral arrangements with the sponsor or the sponsor's delegate, but may* not make funeral arrangements, *including pre-need funeral arrangements,* embalm **[**a dead**]** human **[**body**]** *remains,* or conduct funerals, including graveside or committal services, unless the *apprentice is under the direct supervision of the* sponsor **[**is on the premises or at the site of final disposition**]** *or the sponsor's delegate*.

C. An apprentice may not **[**make preneed funeral arrangements or**]** sign a **[**preneed**]** funeral *establishment* contract.

D.—F. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 29 BOARD OF MORTICIANS AND FUNERAL DIRECTORS

10.29.15 Family Security Trust Fund

Authority: Health Occupations Article, §§*7–4A–01,* 7-4A-03(h), 7–4A–04, 7–4A–05, 7–4A–11, 7–4A–12, and 7-4A-13, Annotated Code of Maryland

Notice of Proposed Action

[16-347-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.02—.05**, **.07**, and **.08** under **COMAR 10.29.15 Family Security Trust Fund**. This action was considered at a public meeting on October 14, 2016, notice of which was given by publication on the Board's website at http://dhmh.maryland.gov/bom/Pages/home.aspx pursuant to General Provisions Article, §3–302(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to:

(1) Clarify that representatives from two of the State's trade associations sit on the Family Security Trust Fund Advisory Committee;

(2) Provide that a preneed contract may be entered into by a licensed mortician, a licensed funeral director, or by a surviving spouse along with their supervising mortician or supervising funeral director;

(3) Provide that the holder of a surviving spouse license cannot enter into a contractual agreement for mortuary sciences services or merchandise between a buyer and a funeral establishment;

(4) Require that fee notices be sent out by first class mail or by electronic means;

(5) Clarify that failure to pay the required fee and late fee by the required date may result in possible suspension of the supervising mortician's license;

(6) Prohibit the Board from issuing a license to an establishment until payment of the required fees, including the late fee, is received;

(7) Provide that required contributions to the Fund may not be prorated;

(8) Clarify certain procedures for filing a claim to the Fund, for receiving compensation from the Fund, and for recovering funds from those deemed responsible for a claim to the Fund; and

(9) Provide that, if the Fund falls below $1 million, the Board shall assess a mandatory contribution to the Fund which the Board may deem to be less than the yearly $375 payment.

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 January 23, 2017. A public hearing has not been scheduled.

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) "Advisory Committee" means a committee comprised of three Board members and a representative from **[**both**]** *two* of the trade associations which is assisted by Board Counsel provided by the Attorney General's Office and Board Administrative personnel to administer the Fund.

(2)—(3) (text unchanged)

(4) "Claimant" means an individual**[**,**]** or legal representative of the individual**[**, or any other individual who on behalf of themselves or any other individual files a claim for loss**]**.

(5)—(6) (text unchanged)

(7) "Preneed contract" means an agreement entered into by a licensed mortician, a licensed funeral director, or a holder of a surviving spouse license *with a supervising mortician or a supervising funeral director* with a buyer in advance of the death of that individual or beneficiary.

(8) "Seller" means a licensed mortician**[**,**]** *or* licensed funeral director**[**, or a holder of a surviving spouse license**]** who agrees to sell certain mortuary sciences services or merchandise in a contractual arrangement between a buyer and a funeral establishment.

.03 Mandatory Fees.

A. (text unchanged)

B. The Board shall send out fee notices to the licensed establishments via first class mail *or by any electronic means* by September 1.

C.—D. (text unchanged)

E. If the establishment does not pay the mandatory fee *and the late fee* by December 30, the Committee shall refer the delinquent establishments to the Board for formal action *to include possible suspension of the supervising mortician license*.

F. **[**The**]** *In addition to any applicable mandatory late fee, the* Board **[**shall**]***:*

(1) Shall assess a $40 fee for returned checks*; and*

(2) May not issue a license until the payment is made, including the late fee if after December 1.

G. (text unchanged)

H. Mandatory contributions to the Fund may not be prorated.

.04 The Family Security Trust Fund.

A. The Board shall:

(1) Collect *the mandatory* contributions;

(2) Deposit *the* funds;

(3)—(4) (text unchanged)

B.—D. (text unchanged)

E. Once the Fund has accumulated a balance of $1,000,000 the Board **[**may**]** *shall* cease to collect the annual fee.

F. **[**Once**]** *If* the Fund **[**balance is**]** *falls* below $1,000,000, the Board shall reinstate **[**the collection of the annual**]** *a* fee *up to $375 to be assessed by the Board*.

G.—H. (text unchanged)

.05 Filing a Claim.

A. (text unchanged)

B. The Board shall issue a final order against a licensee**[**, funeral establishment, or corporation,**]** for violation involving a transaction that relates to preneed funeral planning that occurred in the State and falls within its jurisdiction.

C. The claimant shall:

(1)—(2) (text unchanged)

(3) Present all claims for losses to the **[**Advisory Committee**]** *Board* within 1 year:

(a)—(b) (text unchanged)

(c) At a later date at the discretion of the **[**Committee**]** *Board*.

D. (text unchanged)

E. All claims shall be filed with the**[**:

(1) Fund; and

(2) Advisory committee chair, whose name and address shall appear on the claim form**]** *Fund*.

F. (text unchanged)

.07 Restitution.

A. A claimant may receive compensation from the Fund for an actual preneed trust fund loss that occurred on or after January 1, 2010. All payments shall be a matter **[**of privilege and not of right**]** *to be decided by the full Board in its discretion*.

[B. The Board of Morticians and Funeral Directors shall determine to its satisfaction that the preneed seller does not posses the financial means to deliver or provide the prearranged merchandise or service.**]**

[C.**]** *B.*—**[**D.**]** *C.* (text unchanged)

[E. The payment of claims shall be made in the order in which the claim was received by the Board.**]**

[F.**]** *D.* The President of the Board **[**and the President of the Advisory Committee**]** shall sign **[**off on the payment of**]** claims *by designation to appropriate staff for payment from the Fund*.

[G.**]** *E*. (text unchanged)

[H.**]** *F*. If at any time**[**, in the opinion of the Advisory Committee,**]** there are not sufficient funds on hand to pay all claims in full, the **[**Advisory Committee**]** *Board* may, in its discretion, pay the approved claims pro rata or defer payment until such time as adequate funds are available.

[I.**]** *G.* The **[**Advisory Committee**]** *Board* shall determine the maximum cumulative amounts which shall be paid in respect to any one claim or multiple claims by a single claimant arising from the same licensee involved in either a client or fiduciary relationship. The percentage of payment on the dollar remains the same for all victims of the same licensee.

.08 Recovery of Funds.

A. In the event restitution is made to a claimant under this chapter, the Board **[**shall claim the reimbursed amount and**]** may bring action it deems advisable against any person, including a **[**preneed**]** licensee *who is deemed responsible for the claim*.

B. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 54 SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

10.54.03 Retail Food and Pharmacy Vendors

Authority: Health-General Article, §§2-104(b), 18-107(a), and 18-108, Annotated Code of Maryland

Notice of Proposed Action

[16-338-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.03**, **.04**, **.07—.11**, **.14—.16**, **.18**, and **.19**, repeal existing Regulation **.13**, and adopt new Regulation **.13** under **COMAR 10.54.03 Retail Food and Pharmacy Vendors**.

Statement of Purpose

The purpose of this action is to:

(1) Refine and clarify requirements and practices for vendors authorized by the Maryland WIC program including updates to definitions and vendor application, authorization, and disqualification processes;

(2) Limit authorization of "pharmacy only" vendors to areas where not authorizing these vendors would create a participant hardship;

(3) Remove the WIC-authorized foods list from regulations; and

(4) Amend certain amounts of minimum required stock.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. Reducing the number of "pharmacy only" vendors in the WIC program will help the Maryland WIC program meet USDA food cost containment requirements. The cost of infant formula sold at "pharmacy only" vendors is significant and special formulas are not always available. WIC has negotiated a lower cost with the Community Action Program of Lancaster County, PA (CAP-Lancaster). CAP-Lancaster's retail markup is approximately two-thirds that of "pharmacy only" vendors. Maryland WIC participants can obtain formula from CAP-Lancaster directly, either by picking it up at the local WIC office or by having it delivered to their residence. If participants choose, they can instead use WIC instruments for formula at an authorized food store/pharmacy combination vendor (such as Safeway or Giant) or a pharmacy only vendor. However, if vendors cannot obtain the prescribed formula through their distributors, participants are referred back to the CAP-Lancaster program to obtain the formula. Any savings realized by participants using CAP-Lancaster for formula are required to be returned to the USDA at the end of the grant year.

One independently owned pharmacy and 24 CVS Pharmacy chain stores will be impacted by this change. Combined, these vendors make up only 2.25 percent, or $13,865.58, of the total special formula sales redeemed by the WIC program.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(-)	$13,865.58
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

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

D. The vendors affected by the amendments include 24 stores in the CVS Pharmacy chain and one independently owned pharmacy. The cost to these vendors is based on the total annual amount of instruments redeemed for special formula sales by these 25 vendors, which they will no longer be able to redeem as a result of changes to these regulations.

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 January 23, 2017. A public hearing has not been scheduled.

.03 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

[(2) "Authorization" means approval by the State agency for a food store, pharmacy, food store/pharmacy combination, or a military commissary to redeem WIC food instruments.**]**

(2) "Accounting records" means:

(a) Legible records that show actual numbers of eligible food sales from the vendor and not an estimated number or percentage of eligible food sales; and

(b) Actual WIC sales for each individual day.

(3) "Authorization" means approval by the State agency for a food store, pharmacy only, food store/pharmacy combination, or a military commissary to redeem WIC food instruments as a vendor.

[(3)**]** *(4)*—**[**(9)**]** *(10)* (text unchanged)

[(10)**]** *(11)* "Food instrument" means a voucher, check, coupon, electronic benefits **[**transfer**]** *issuance* card **[**(EBT)**]** *(eWIC),* or other document that is used to obtain supplemental foods.

[(11) "Food instrument type" means a food instrument designation based on the type and amount of WIC food items specified on the food instrument.**]**

(12) (text unchanged)

(13) "Food sales" means sales of all SNAP eligible foods intended for home preparation and consumption, as set forth in **[**7 C.F.R. §246.2**]** *7 CFR §246.2*.

(14)—(16) (text unchanged)

(17) "Inventory audit" means an audit conducted over a specific period of time in order to determine whether a vendor's claimed reimbursement for the sale of an amount of a specific food item exceeds the vendor's documented inventory of that item.

(18) "Inventory invoices" mean sales receipts for WIC food purchased by the vendor for resale by the vendor, from a supplier which can be a wholesaler, distributor, manufacturer, or other retailer.

[(17)**]** *(19)*—**[**(19)**]** *(21)* (text unchanged)

[(20)**]** *(22)* "Monitoring" means **[**an inspection of an authorized vendor's premises and redeemed food instruments by a Program representative**]** *assessing vendor compliance with program requirements.*

[(20-1)**]** *(23)*—**[**(23)**]** *(26)* (text unchanged)

[(24)**]** *(27)*—**[**(25)**]** *(28)* (text unchanged)

[(26)**]** *(29)* "Pharmacy *only*" means an establishment that **[**has**]***:*

(a) Has been issued a permit to operate by the State Board of Pharmacy **[**and that does**]***;*

(b) Does not have a food store under the same ownership on its premises*; and*

(c) Once authorized, can only accept WIC food instruments that prescribe infant formula and WIC-eligible medical foods.

[(27)**]** *(30)*—**[**(29)**]** *(32)* (text unchanged)

[(30)**]** *(33)* "Region" means a designated area of the State, as set forth in **[**§B(31)—(36)**]** *§B* of this regulation, for administration of the WIC Program including vendor selection and peer group designation.

[(31)**]** *(34)*—**[**(39)**]** *(42)* (text unchanged)

[(40)**]** *(43)* (text unchanged)

[(41)**]** *(44)*—**[**(48)**]** *(52)* (text unchanged)

(53) "WIC-authorized foods list" means a list of foods authorized by the Maryland WIC program for purchase by Maryland WIC participants.

[(49)**]** *(54)* (text unchanged)

.04 Authorization Requirements.

A.—B. (text unchanged)

C. In order to receive authorization from the State agency, a vendor shall:

(1) Submit a completed vendor application to the State agency**[**;**]** *that includes:*

(a) Two signed vendor agreements; and

(b) A signed vendor tax release form;

(2)—(6) (text unchanged)

[(7) Successfully complete an on-site review pursuant to Regulation .08 of this chapter;

(8) Be accessible to persons with disabilities;

(9) Upon receipt of the vendor agreement from the State agency, which will be sent to the vendor applicant when it is in compliance with the other provisions of this regulation:

(a) Complete and sign the vendor agreement; and

(b) Submit the vendor agreement to the State agency; and**]**

(7) Be accessible to persons with disabilities;

(8) Successfully complete an on-site review pursuant to Regulation .08 of this chapter; and

[(10)**]** *(9)* (text unchanged)

D. (text unchanged)

E. **[**In order to receive authorization from the State agency as a pharmacy vendor only, a pharmacy shall**]** *Pursuant to Regulation .19 of this chapter, if the State agency determines that a participant hardship exists, where access to special infant formula and WIC-eligible medical foods are not available through a food/pharmacy combination store, the State agency, at its sole discretion, may authorize a pharmacy only vendor that shall*:

(1) Adhere to the requirements set forth in **[**§C(1), (3), (5)—(6), and (8)—(10)**]** *§C(1), (3), (5)—(7), and (9)* of this regulation;

(2) (text unchanged)

(3) Only accept WIC food instruments prescribing infant formula *and WIC-eligible medical foods*.

F. Except for a pharmacy *only* or military commissary, a vendor applicant shall have actual highest current shelf prices that are less than or equal to 125 percent of the peer group average in the vendor applicant's region during the month of application, as determined by the State agency for each of the food packages set forth in Regulation .06A of this chapter.

G.— K. (text unchanged)

.07 Vendor Application Packet and Dates.

A. (text unchanged)

B. The application packet shall consist of the following:

(1)—(2) (text unchanged)

(3) The **[**authorized foods list**]** *WIC-authorized foods list*;

(4) (text unchanged)

(5) Instructions for completing the application *for vendor authorization*; **[**and**]**

[(6) An application form.**]**

(6) An application for vendor authorization;

(7) The vendor tax release form; and

(8) Two vendor agreements.

C. A vendor applicant denied authorization three times in **[**a calendar year**]** *a 12-month period* may not reapply until **[**1 year**]** after **[**the last denial date**]** *12 months have passed since the last denial date*.

.08 On-Site Review of Vendor Applicants.

A. (text unchanged)

B. Except as provided in §A of this regulation, the State agency shall conduct an unscheduled on-site review of a vendor applicant's store within 60 days of receipt of an application to ensure that the store meets the requirements for authorization as set forth in Regulation **[**.04C and D**]** *.04C(1)—(7) and D* of this chapter.

.09 Grant, Retention, and Denial of Authorization.

A.—B. (text unchanged)

C. Authorization Retained. A vendor retains its authorization until the:

(1) Vendor's authorization is **[**suspended**]** *terminated* as a sanction for a Program violation in accordance with this chapter;

(2)—(5) (text unchanged)

D.—E. (text unchanged)

.10 Food Package Prices After Authorization.

A. After authorization, a vendor, other than a pharmacy *only* or military commissary, shall maintain prices for each of the food packages set forth in Regulation .06A of this chapter that are less than or equal to 125 percent of the peer group average for each food package.

B. (text unchanged)

C. The State agency shall notify a vendor, other than a pharmacy *only* or a military commissary, that fails to submit its prices on the vendor price list form or through the State agency's online submission system when requested to do so that, if the price list form or online price submission is not received by the Program within 10 business days of the State agency's request, the vendor's authorization shall be **[**suspended**]** *disqualified* for **[**1 year**]** *12 months from the date of disqualification.*

D. If a vendor, other than a **[**pharmacy or a**]** military commissary, submits prices on the vendor price list form that make its food package price more than 125 percent of the peer group average for that food package, or the food package prices are determined by the WIC Management Information System calculation to exceed 125 percent of the peer group average, the State agency shall notify the vendor that:

(1) (text unchanged)

(2) It **[**may**]** *shall* lower its actual highest shelf prices for the WIC foods **[**or**]** *and* resubmit the vendor price list form or online price submission to the State agency within 10 days following the notification; and

(3) If the vendor's resubmitted prices indicate that a food package will cost the Program more than 125 percent of the peer group average for that food package, the State agency may disqualify the vendor for **[**1 year**]** *12 months from the date of disqualification.*

E. If, at any time, a vendor, other than a **[**pharmacy or a**]** military commissary, has actual highest shelf prices that make any food package price more than 125 percent of the peer group average, the State agency shall notify the vendor that:

(1) The vendor **[**may**]** *shall* lower its actual highest shelf prices for the WIC foods within 10 days; and

(2) If the vendor's prices remain so that a food package will cost the Program more than 125 percent of the peer group average, the **[**State agency**]** *vendor's authorization* shall **[**disqualify the vendor**]** *be disqualified* for **[**1 year**]** *12 months from the date of disqualification.*

F. If, in 2 consecutive reporting months, a vendor, other than a pharmacy only **[**store**]** or a military commissary, is determined by the WIC Management Information System calculation to have food package prices that exceed 125 percent of the peer group average, the **[**State agency may disqualify the vendor**]** *vendor's authorization shall be disqualified* for **[**1 year**]** *12 months from the date of disqualification*.

G. The State agency may request that a vendor, other than a pharmacy *only* or a military commissary, submit semi-annual price lists at the State agency's sole discretion and may use these price lists and the WIC Management Information System for calculation of excess charges if it is determined that excess charges have occurred.

H.—I. (text unchanged)

J. For the purpose of cost containment, the State agency:

(1) Shall use **[**only use**]** the methodology provided by the U.S. Department of Agriculture, Food Nutrition Service to ascertain whether or not the vendor derives more than 50 percent of the vendor's eligible food sales revenue from the redemption of WIC food instruments; and

(2) (text unchanged)

.11 Maximum Reimbursement to Vendors.

A. Food Store, Food Store/Pharmacy Combination, and Pharmacy *Only* Vendors. The State agency shall establish a maximum price payable for each food instrument, which shall be calculated as follows:

(1)—(3) (text unchanged)

B.—C. (text unchanged)

.13 WIC-Authorized Foods.

A. The State agency shall:

(1) Maintain the WIC-authorized foods list; and

(2) Make the list available to all participants and authorized WIC vendors.

B. A vendor shall keep a copy of the Program's current WIC-authorized foods list:

(1) At each cash register where WIC transactions are handled; and

(2) On-site at the authorized vendor location along with the vendor manual.

C. The WIC-authorized foods list shall be used in conjunction with the WIC food instrument to identify foods items that are eligible for purchase using WIC food instruments.

D. Food instruments may require that program participants purchase specific manufacturers or brands that are not included in the WIC-authorized foods list.

E. Authorized vendors shall sell WIC-designated brands for food categories identified in the WIC-authorized foods list.

.14 Minimum Required Stock.

A. A food store or food store/pharmacy combination vendor shall maintain in the store during regular business hours the following minimum stock:

(1) Fluid milk:

(a) (text unchanged)

(b) 10 gallons 1-percent or **[**10 gallons**]** fat-free;

(2) (text unchanged)

(3) Domestic cheese:

(a)—(b) (text unchanged)

(c) *8 or* 16-ounce packages only; and

(d) (text unchanged)

(4) (text unchanged)

(5) Frozen concentrate 100-percent juice:

[(a) Two brands;**]**

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

[(c) Nine 11.5-ounce to 12-ounce**]**

(b) Six 11.5—12-ounce cans;

(6) Thirty-two total infant fruits *and vegetables*:

(a) Two varieties *of each*;

(b) 16 **[**3.5-ounce to**]** 4-ounce containers *of each*; and

(c) Plain **[**or**]**, a combination of **[**fruit ingredients**]** *fruits, a combination of vegetables, or a combination of fruits and vegetables*;

[(7) Infant vegetables:

(a) Two varieties;

(b) 16 3.5-ounce to 4-ounce containers; and

(c) Plain or, a combination of vegetable ingredients;**]**

[(8)**]** *(7)* Infant **[**meat**]** *meats*:

(a)—(b) (text unchanged)

[(9)**]** *(8)* Dry cereal:

(a) Corn, wheat, oats, or rice:

(i) Six *12-ounce or larger* boxes; and

(ii) Two varieties; **[**and**]**

(b) Whole grain wheat or oats:

(i) Six *12-ounce or larger* boxes; and

(ii) (text unchanged)

(c) At least one hot cereal *in an 11.8-ounce container or larger*;

[(10) Six 8-ounce or 16-ounce boxes dry infant cereal as specified by the WIC infant cereal rebate contract:**]**

(9) Infant cereal:

(a) Six 8-ounce or 16-ounce containers dry;

[(a)**]** *(b)*—**[**(b)**]** *(c)* (text unchanged)

[(11)**]** *(10)* Peanut butter:

(a) (text unchanged)

(b) Six **[**16-ounce to 18-ounce**]** *16—18-ounce* containers;

[(12)**]** *(11)* **[**Dry and water-packed canned beans**]** *Beans*:

(a) (text unchanged)

(b) 12 **[**15-ounce to 16-ounce**]** *15—16-ounce packed in water* cans in three varieties;

[(13) 30 ounces, two varieties canned tuna, salmon, and sardines packed in water:

(a) Chunk light tuna in 5-ounce to 6-ounce cans;

(b) Pink salmon in 5-ounce to 7.5-ounce cans; or

(c) Sardines in 3.75-ounce cans;

(14) Vegetables and fruits in two varieties and a total value of $32:

(a) Fresh, whole or cut;

(b) Frozen or canned; and

(c) Loose or pre-packaged;

(15) 100-percent whole grain bread and rolls, brown rice, soft corn tortillas, or whole wheat tortillas in two varieties and a total of 4 pounds:

(a) 15-ounce to 16-ounce packages for rolls;

(b) 16-ounce packages for bread;

(c) 16-ounce packages for tortillas; and

(d) 16-ounce packages for brown rice; and**]**

(12) Canned fish:

(a) 30-ounces total and packed in water; and

(b) Two varieties of:

(i) Canned chunk light tuna in 5—6-ounce cans;

(ii) Pink salmon in 5—7.5-ounce cans; and

(iii) Sardines in 3.75-ounce cans;

(13) Fruits and vegetables:

(a) A total value of $32;

(b) Two varieties of fruits, fresh, whole or cut, loose or prepackaged, frozen or canned; and

(c) Two varieties of vegetables, fresh, whole or cut, loose or prepackaged, frozen or canned;

(14) Bread, rolls, tortillas, and rice in two varieties and a total of 4 pounds:

(a) 100 percent whole grain or whole wheat bread, 16-ounce packages;

(b) 100 percent whole grain or whole wheat rolls, 15—16-ounce packages;

(c) Dry, plain brown rice, 16-ounce packages; or

(d) Soft corn or whole wheat tortillas, 16-ounce packages; and

[(16)**]** *(15)* Infant formula:

(a) **[**16**]** *17* 13-ounce **[**cans, or cans**]** *containers, or containers* of **[**current can**]** *the currently authorized* size, of liquid concentrate infant formula **[**containing DHA/RHA**]** as specified by the WIC infant formula rebate contract;

(b) **[**24**]** *27* 12.4-ounce **[**cans, or cans**]** *containers, or containers* of **[**current can**]** *the currently authorized* size, of powdered infant formula **[**containing DHA/RHA**]** as specified by the WIC infant formula rebate contract;

(c) **[**18 13-ounce cans, or cans**]** *19 12.1-ounce containers, or containers* of **[**current can**]** *the currently authorized* size, of soy-based liquid concentrate infant formula **[**containing DHA/RHA**]** as specified by the WIC infant formula rebate contract; and

(d) **[**Six**]** *10* 12.9-ounce **[**cans, or cans**]** *containers, or containers* of **[**current can**]** *the currently authorized* size, of soy-based powdered infant formula **[**containing DHA/RHA**]** as specified by the WIC infant formula rebate contract.

B. A pharmacy *only* or food store/pharmacy combination vendor shall provide special formulas, *or WIC-eligible medical foods* within 48 hours, excluding weekends and holidays, for a request by a participant or the Program.

.15 Required Vendor Practices.

A. The State agency or its representative shall conduct **[**monitoring and**]** *inventory audits,* compliance buys, *and monitoring* to ensure that authorized vendors comply with required vendor practices.

B. General Requirements.

(1) A vendor shall:

(a)—(c) (text unchanged)

(d) Display a current food service facility license, issued by the local health department or department of environment, or *if* a *pharmacy only or a food store/pharmacy combination, a* pharmacy permit issued by the State Board of Pharmacy, in a location visible to Program representatives;

(e)—(h) (text unchanged)

[(i) Accept training from the WIC Program as required by the Program;**]**

(i) Attend a WIC training that has been required by the Program for a vendor with a high rate of:

(i) Errors;

(ii) Rejected checks;

(iii) Complaints; or

(iv) Other minor violations;

(j) (text unchanged)

(k) If a pharmacy *only* or a food store/pharmacy combination **[**store**]**:

(i) Provide special formulas *and WIC-eligible medical foods* within 48 hours of a request by a participant or the Program;

(ii) (text unchanged)

(iii) If a pharmacy only vendor, only accept food instruments prescribing infant formula *and WIC-eligible medical foods*;

(l) Maintain accounting records *that are* relevant to the vendor's performance under the vendor agreement for 3 years, for review at reasonable times by State agency representatives or other authorized State or federal officials**[**.**]***;*

(m)—(p) (text unchanged)

(q) For the food packages set forth in Regulation .06A of this chapter, maintain prices that are less than or equal to 125 percent of the peer group average as determined by the WIC Management Information System calculation for each food package; **[**and**]**

(r) Have a representative attend and participate in at least one State or local agency interactive training session each calendar year, if the State agency:

(i) Gives the vendor 14 days notice of a scheduled training session**[**,**]***;* and

(ii) Holds the training session in the vendor's region**[**.**]***; and*

(s) If more than 30 days are needed to reopen the vendor's business, reapply for authorization and be approved as a WIC vendor in order to obtain authorization to operate as a WIC Vendor.

(2) — (3) (text unchanged)

(4) Accounting Records. Accounting records shall include, but are not limited to:

(a) Sales and use tax returns;

(b) U.S. individual or business tax returns;

(c) Daily sales journals or daily ledgers;

(d) Sales receipts or register tape;

(e) Inventory invoices; and

(f) A breakdown of sales between SNAP eligible foods and non-eligible foods.

(5) Inventory Invoices.

(a) Inventory invoices shall include the:

(i) Name and address of the supplier;

(ii) Date of purchase;

(iii) Description of the exact items purchased, including size, stock number, and UPC code if available;

(iv) Unit price of the items;

(v) Total quantity purchased; and

(vi) If inventory invoices do not completely describe the actual item, verifiable computer codes for the item.

(b) Inventory invoices for infant formula shall only be accepted from those wholesalers, distributors, and retailers listed on Maryland's Infant Formula Directory.

C. Transactional Requirements.

(1) A vendor shall:

(a)—(e) (text unchanged)

(f) At the time of purchase, give a participant a receipt indicating the store *name*, date *of transaction*, and total dollar amount for items purchased with a food instrument and that the sale was a WIC transaction;

(g)—(n) (text unchanged)

(o) Obtain infant formula from only the following manufacturer, distributor, wholesaler, and retailer sources:

(i) (text unchanged)

[(ii) Associated Wholesalers, Inc.;

(iii) AWI;**]**

[(iv)**]** *(ii)* (text unchanged)

[(v)**]** *(iii)* **[**Bill's**]** *Bell's* Wholesale Grocery, Inc.;

[(vi)**]** *(iv)*—**[**(vii)**]** *(v)* (text unchanged)

[(viii)**]** *(vi)* **[**C&S**]** *C & S* Wholesale Grocers;

[(ix) Cho Wholesaler, Inc.;**]**

(vii) Delhaize;

[(x) Economy Wholesale Co.;

(xi) Food Lion Distribution;

(xii) George J. Falter;**]**

[(xiii)**]** *(viii)* (text unchanged)

(ix) Lancaster Distribution Center;

[(xiv) Maryland Cash & Carry;**]**

(x) McKesson Corporation;

[(xv)**]** *(xi)* (text unchanged)

[(xvi)**]** *(xii)* Moran Foods, Inc./*Save-a-Lot Distribution Center*;

[(xvii)**]** *(xiii)*—**[**(xviii)**]** *(xiv)* (text unchanged)

(xv) Nutricia North America;

[(xix) PBM Nutritionals**]**

(xvi) Rite Aid Corporation;

(xvii) Solus Products, LLC;

[(xx)**]** *(xviii)* (text unchanged)

(xix) Toys R Us, Inc.

[(xxi) Any other lawful wholesaler, distributor, manufacturer, or retail source of infant formula, provided that the WIC vendor notifies the Program that the vendor is using the source to obtain infant formula.**]**

(2)—(4) (text unchanged)

D. Post-Transactional Requirements.

(1) A vendor shall:

(a)—(d) (text unchanged)

(e) In the case of a food instrument not paid by the bank used by the Program, seek reimbursement from the State agency only; **[**and**]**

(f) Reimburse the Program for the loss sustained by the Program due to theft, fraud, or improper handling of food instruments by vendor personnel or agents*; and*

(g) Surrender improperly handled food instruments to WIC representatives upon request.

(2) A vendor may not:

(a) (text unchanged)

(b) Permit the return of food purchased with a food instrument in exchange for cash or another item; **[**or**]**

(c) Claim reimbursement for the sale of an amount of a specific food item that exceeds the vendor's documented inventory of that item for a specific period of time*; or*

(d) Claim reimbursement for vendor bank fees.

(3) (text unchanged)

.16 Vendor Sanctions.

A. The Program may sanction a vendor that fails to comply with a required practice in Regulation .15B(1)(a)—(k) and (q), (2)(b) and (f)—(h), C(1)(a)—(g) and (h)—(n), (2)(a)—(c) and (e)—(f), (3), and D(1)(a)—(b) and (e), and (2)(a) of this chapter as follows:

(1) (text unchanged)

(2) Disqualification for 1 year for a pattern of violations of the same provisions within a **[**1-year**]** *12-month* period; and

(3) Disqualification for 1 year for a combination of six violations within a **[**1-year**]** *12-month* period.

B.—E. (text unchanged)

F. The Program shall sanction a vendor that fails to comply with a required practice in Regulation .15B(2)(a), C(2)(d) and (g), and D(1)(c)—(d) and (2)(c) of this chapter by:

(1) A written warning if one violation is detected in any **[**6-month**]** *12-month* period; or

(2) Disqualifying the vendor for 3 years for two or more violations in any **[**6-month**]** *12-month* period.

G. (text unchanged)

H. **[**The Program shall:**]** *Disqualification.*

(1) **[**Disqualify**]** *Except in circumstances described in §H(2) of this regulation, the Program shall disqualify* a vendor that has been disqualified **[**or assessed a money penalty by the SNAP in violation of Regulation .15B(1)(m) of this chapter for the same length of time as the SNAP disqualification; or**]** *by SNAP in violation of Regulation .15B(1)(m) of this chapter for the same length of time as the SNAP disqualification.*

(2) If **[**the State agency determines that disqualification would result in inadequate participant access, impose a civil money penalty under the formula set forth in 7 CFR §246.12(1)(1)(x)**]** *disqualification of the vendor will result in inadequate participant access in accordance with Regulation .19 of this chapter, the State agency shall impose a civil money penalty in lieu of disqualification*.

(3) Except in circumstances described in §H(4) of this regulation, the Program shall disqualify a vendor that has been assessed a civil money penalty for hardship by SNAP instead of disqualification by SNAP in violation of Regulation .15B(1)(m) of this chapter, for the same period for which the vendor would otherwise have been disqualified by SNAP.

(4) If disqualification of a vendor that has been assessed a civil money penalty for hardship by SNAP instead of disqualification by SNAP would result in inadequate participant access in accordance with Regulation .19 of this chapter, the Department may not:

(a) Disqualify the vendor; or

(b) Impose a civil money penalty in lieu of disqualification.

I.—J. (text unchanged)

K. The State *agency* shall notify the USDA of a disqualification or money penalty:

(1)—(2) (text unchanged)

L.—P. (text unchanged)

.18 Vendor Appeals.

A.—B. (text unchanged)

C. Request for Hearing.

(1) A vendor or vendor applicant shall preserve the right to a hearing, if a hearing is desired, by filing a written request for a hearing with the Director of the Program within 10 days of the receipt of the notice of proposed **[**suspension**]** *disqualification* or denial.

(2) (text unchanged)

D. (text unchanged)

E. A vendor may not appeal the following actions:

(1)—(4) (text unchanged)

(5) The validity or appropriateness of the State agency's prohibition of incentive items and the State agency's denial of an **[**above-50-percent**]** *above 50 percent* vendor's request to provide an incentive item;

(6) (text unchanged)

(7) The validity or appropriateness of the State agency's vendor peer group criteria and the criteria used to identify vendors that are **[**above-50-percent**]** *above 50 percent* vendors or comparable to **[**above-50-percent**]** *above 50 percent* vendors;

(8)—(10) (text unchanged)

.19 Participant Hardship.

A. Except for the sanction prescribed in Regulation .16E of this chapter, the State agency may determine that a participant hardship would exist if a vendor is disqualified and one of the following conditions would result:

(1)—(2) (text unchanged)

(3) Ten or more participants can only be served properly by a particular vendor because of a language barrier **[**or**]**, religious dietary needs*, access to exempt infant formula, or access to WIC-eligible medical foods.*

B.—G. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Title 12
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

Subtitle 04 POLICE TRAINING *AND STANDARDS* COMMISSION

12.04.01 General Regulations

Authority: Correctional Services Article, §2-109; Public Safety Article, §3-208(a); Annotated Code of Maryland

Notice of Proposed Action

[16-349-P]

The Secretary of Public Safety and Correctional Services, in cooperation with the Police Training and Standards Commission, proposes to amend Regulations **.01** and **.16** under **COMAR 12.04.01 General Regulations**. This action was considered by the Police Training and Standards Commission at a public meeting held on October 05, 2016.

Statement of Purpose

The purpose of this action is to:

(1) Under COMAR 12.04.01.01, amend the definitions of Commission and Controlled Dangerous Substance; and

(2) Under COMAR 12.04.01.16, amend language concerning certification standards for applicants to be police officers in recognition of the Maryland General Assembly's action to decriminalize the possession of small amounts of marijuana.

While the penalty for possession of a small amount of marijuana has been reduced, it is still illegal in Maryland.

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 Albert Liebno, Acting Director of the Police Training and Standards and Correctional Training Commissions, Maryland Department of Public Safety and Correctional Services, 6852 4th Street Sykesville, MD 21784, or call 410-875-3602, or email to albert.liebno@maryland.gov, or fax to 410-875-3584. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

Open Meeting

Final action on the proposal will be considered by Police Training and Standards Commission during a public meeting to be announced.

.01 Definitions.

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

B. Terms Defined.

(1) — (4) (text unchanged)

(5) *Commission.*

(a) "Commission" means the Police Training *and Standards* Commission or a representative authorized to act on behalf of the Commission.

(b) "Commission" includes all references to Police Training Commission, now known as the Police Training and Standards Commission.

(6) Controlled Dangerous Substance.

(a) "Controlled dangerous substance", *unless specified otherwise,* has the meaning stated in Criminal Law Article, §5-101, Annotated Code of Maryland.

(b) "Controlled dangerous substance", *unless specified otherwise,* includes substances identified under Criminal Law Article, §5-708, Annotated Code of Maryland.

(c) (text unchanged)

(7) — (21) (text unchanged)

.16 Prior Substance Abuse by Applicants for Certification.

A. (text unchanged)

B. General.

(1) — (2) (text unchanged)

(3) For the purpose of this regulation, marijuana is considered to be separate from a controlled dangerous substance defined under Regulation .01B of this chapter.

C. Prohibitions — Initial Certification. An individual is ineligible for initial certification as a police officer in Maryland if the individual has:

(1) — (2) (text unchanged)

(3) Illegally used a controlled dangerous substance, narcotic drug, or marijuana for any purpose within the **[**3 years**]** *36 months* before application for certification;

(4) Ever illegally used a controlled dangerous substance, *or* narcotic drug**[**, or marijuana**]** for other than experimentation as specified under §D of this regulation; or

(5) (text unchanged)

D. Presumption of Experimentation. The illegal use of a controlled dangerous substance, *or* narcotic drug**[**, or marijuana**]** is not experimentation if the applicant:

(1) (text unchanged)

(2) Other than heroin, PCP, LSD, or marijuana, used any controlled dangerous substance or narcotic drug, or any combination of controlled dangerous substances or narcotic drug that exceeds:

(a) (text unchanged)

(b) One time since becoming 21 years old**[**; or**]**.

[(3) Used marijuana:

(a) More than 20 times; or

(b) Five times since becoming 21 years old.**]**

E. (text unchanged)

F. Indication of Use of a Controlled Dangerous Substance, Narcotic Drug, or Marijuana.

(1) If any part of the background investigation indicates an **[**applicant's current**]** *applicant currently* or **[**prior use of**]** *previously used* a controlled dangerous substance, narcotic drug, or marijuana, the law enforcement agency shall investigate to determine if the use falls under the prohibitions specified in this regulation.

(2) — (5) (text unchanged)

G. Petition for Special Consideration.

(1) An agency head submitting an application for certification for an individual with a history of illegal use of a controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** may petition the Commission based on articulated unique circumstances of the individual's use of a controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** for a final determination as to the use being experimentation as specified under §D of this regulation.

(2) The agency head, or a designee, submitting a petition under §G(1) of this regulation shall:

(a) Specify the illegal controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** used;

(b) Indicate the number of times the illegal controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** was used;

(c) (text unchanged)

(d) Indicate how the information concerning the use of the illegal controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** came to be known by the agency;

(e) (text unchanged)

(f) Identify the specific factors that the agency head believes the Commission should consider when making a determination as to experimentation that, at a minimum, include information concerning:

(i) — (iii) (text unchanged)

(iv) How the illegal controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** was obtained;

(v) How the illegal controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** was ingested;

(vi) — (viii) (text unchanged)

(g) Submit the petition to the Executive Director of the Police **[**and Correctional**]** Training **[**Commissions**]** *and Standards Commission.*

(3) The Executive Director shall submit a petition received under §G(2) of this regulation to the Police Training *and Standards* Commission at the next scheduled meeting following receipt if the petition:

(a) — (b) (text unchanged)

H. Hearing Not Required.

(1) An individual applying for certification has no right to appear before the *Police Training and Standards* Commission for the purpose of challenging a law enforcement agency's determination that the individual used a controlled dangerous substance**[**,**]** *or* narcotic drug**[**, or marijuana**]** contrary to the standards established by this regulation.

(2) The *Police Training and Standards* Commission's consideration of a petition under §G of this regulation is not a hearing.

STEPHEN T. MOYER
Secretary of Public Safety and Correctional Services

Title 13A
STATE BOARD OF EDUCATION

Subtitle 04 SPECIFIC SUBJECTS

13A.04.19 Program in Cosmetology

Authority: Business Occupations and Professions Article, §§5-301—5-305, 5-509, 5-523, and 5-608; *Education Article, §§21-201—21-203;* Annotated Code of Maryland

Notice of Proposed Action

[16-341-P]

The Maryland State Board of Education proposes to amend Regulations **.01** and **.02**, amend and recodify existing Regulations **.06**, **.07**, and **.09** to be Regulations **.05**, **.06**, and **.08**, repeal existing Regulation **.03**, and recodify existing Regulations **.04**, **.05**, and **.08** to be Regulations **.03**, **.04**, and **.07** under **COMAR 13A.04.19 Program in Cosmetology**.

This action was considered by the State Board of Education at their meeting on October 25, 2016.

Statement of Purpose

The purpose of this action is to: (1) eliminate Regulation .03 because the State Board of Cosmetology no longer offers a Makeup Artist license; (2) update the name of the Division of Career Technology and Adult Learning to the Division of Career and College Readiness; (3) clarify that students' work-study is conducted under a work-based learning agreement with the school; (4) clarify that the school—not MSDE—is responsible for submitting certifying documentation to the testing vendor; (5) update the names of student organizations cited in the regulations; and (6) update the reference of the teacher certification from COMAR 13A.12.02.47 to 13A12.02.15.

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 Nina Roa, Specialist, Career and Technology Education, Maryland State Department of Education, 200 West Baltimore Street, Baltimore, Maryland 21201, or call 410-767-0467 (TTY 410-333-6442), or email to nina.roa@maryland.gov, or fax to 410-333-2099. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

Open Meeting

Final action on the proposal will be considered by the Maryland State Board of Education during a public meeting to be held on February 28, 2017, 9:00 a.m., at 200 West Baltimore Street, Baltimore, Maryland 21201.

.01 Program Approval.

A. (text unchanged)

B. To obtain approval for a cosmetology program after June 30, 1991, a local school system shall apply to the State Department of Education on a form provided by the Department. The proposal for approval of a cosmetology program shall meet all the requirements in Regulations .02—**[**.08**]** *.07* of this chapter.

.02 Program Completer Requirements for Cosmetology Operator.

A. — B. (text unchanged)

C. Related Instruction.

(1) Related instruction, not to exceed 300 hours, may apply toward the 1,500-hour requirement when the cosmetology teacher approves hours for documented student participation in any of the following activities:

(a) Organizational activities of the **[**Vocational Industrial Clubs of America**]** *Skills USA* which are directly related to the subject of cosmetology;

(b) (text unchanged)

(c) Work-study employment, after successful completion of 1,000 hours of cosmetology operator instruction, which is supervised by a senior cosmetologist**[**.**]** *and conducted under a work-based learning agreement with the school.*

(2) (text unchanged)

D. (text unchanged)

[.06] *.05* Student Records.

A. (text unchanged)

B. The student record shall:

(1) — (3) (text unchanged)

(4) Be **[**the basis for submitting a certificate of completion, on a form prescribed by the State Department of Education, to the State Board of Cosmetologists.**]** *used to comply with the testing vendor's process for certifying student training and verifying student experience.*

[.07] *.06* Cosmetology Teacher.

A. A cosmetology teacher shall possess a senior cosmetology license and shall meet the teacher certification requirements in COMAR **[**13A.12.02.47.**]** *13A.12.02.15.*

B. (text unchanged)

[.09] *.08* Denial, Suspension, and Revocation of Approval.

A. Grounds. The State Board of Education may deny, suspend, or revoke approval of a cosmetology program if the program:

(1) Fails to meet the standards established in Regulations .02—**[**.08**]** *.07* of this chapter;

(2) — (4) (text unchanged)

B. Decision.

(1) The Assistant State Superintendent for the Division of Career **[**Technology and Adult Learning**]** *and College Readiness* shall make a recommendation to the State Board of Education to deny, suspend, or revoke approval of a cosmetology program, stating the basis for the recommendation in writing. A copy of the recommendation shall be provided to the local school system.

(2) — (3) (text unchanged)

C. Reinstatement. The State Department of Education may reinstate approval of a cosmetology program for which approval has been revoked if the local school system:

(1) (text unchanged)

(2) Provides adequate evidence that the cosmetology program:

(a) (text unchanged)

(b) Meets the standards established in Regulations .02—**[**.08**]** *.07* of this chapter.

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Subtitle 04 SPECIFIC SUBJECTS

13A.04.20 Program for Barbers

Authority: Business Occupations and Professions Article, §§4-301, 4-302, 4-511, and 4-514; *Education Article, §§21-201—21-203;* Annotated Code of Maryland

Notice of Proposed Action

[16-342-P]

The Maryland State Board of Education proposes to amend Regulations **.02**, **.04**, **.05** and **.07** under **COMAR 13A.04.20 Program for Barbers**. This action was considered by the State Board of Education at their meeting on October 25, 2016.

Statement of Purpose

The purpose of this action is to: (1) update the name of the Division of Career Technology and Adult Learning to the Division of Career and College Readiness; (2) clarify that the school—not MSDE—is responsible for submitting certifying documentation to the testing vendor; (3) update the names of student organizations cited in the regulations; (4) clarify that students' work-study is conducted under a work-based learning agreement with the school; and (5) update the reference of the teacher certification from COMAR 13A.12.02.47 to 13A12.02.15.

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 Nina Roa, Specialist, Career and Technology Education, Maryland State Department of Education, 200 West Baltimore Street, Baltimore, Maryland 21201, or call 410-767-1904 (TTY 410-333-6442), or email to nina.roa@maryland.gov, or fax to 410-333-2099. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

Open Meeting

Final action on the proposal will be considered by the Maryland State Board of Education during a public meeting to be held on February 28, 2017, 9:00 a.m., at 200 West Baltimore Street, Baltimore, Maryland 21201.

.02 Program Completer Requirements for Barbers.

A.—B. (text unchanged)

C. Related Instruction.

(1) Related instruction, not to exceed 240 hours, may apply toward the 1,200-hour requirement when the teacher of barbering approves hours for documented student participation in any of the following activities:

(a) Organizational activities of the **[**Vocational Industrial Clubs of America**]** *Skills USA* which are directly related to the subject of barbering;

(b) (text unchanged)

(c) Work-study employment after successful completion of 800 hours of barbering instruction, which is supervised by a master barber *and conducted under a work-based learning agreement with the school.*

(2) (text unchanged)

D. (text unchanged)

.04 Student Records.

A. (text unchanged)

B. The student record shall:

(1) — (3) (text unchanged)

(4) Be **[**the basis for submitting a certificate of completion, on a form prescribed by the State Department of Education, to the State Board of Barbers**]** *used to comply with the testing vendor's process for certifying student training and verifying student experience.*

.05 Barber Teachers.

A. A barber teacher shall possess a master barber license and shall meet the teacher certification requirements in COMAR **[**13A.12.02.47.**]** *13A.12.02.15.*

B. (text unchanged)

.07 Denial, Suspension, and Revocation of Approval.

A. (text unchanged)

B. Decision.

(1) The Assistant State Superintendent for the Division of Career **[**Technology and Adult Learning**]** *and College Readiness* shall make a recommendation to the State Board of Education to deny, suspend, or revoke approval of a barber program, stating the basis for the recommendation in writing. A copy of the recommendation shall be provided to the local school system.

(2) — (3) (text unchanged)

C. (text unchanged)

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Subtitle 06 SUPPORTING PROGRAMS

13A.06.07 Student Transportation

Authority: Education Article, §§2-205, 5-205, and 8-410, Annotated Code of Maryland

Notice of Proposed Action

[16-356-P]

The Maryland State Board of Education proposes to amend Regulations **.01**, **.08**, **.09**, and **.10** under **COMAR 13A.06.07 Student Transportation**. This action was considered Education Article, §§2-205, 5-205, and 8-410, Annotated Code of Maryland

Statement of Purpose

The purpose of this action is to (1) increase vehicle damage threshold to $3,000; (2) add definition of "School Vehicle Attendant"; (3) add provision to "School Vehicle Driver"; (4) revise definition of "School Vehicle Driver Trainee"; (4) revise School Vehicle Attendant Qualifications and Disqualifications; (5) revise Instructional Content Requirements for School Vehicle Drivers, School Vehicle Driver Recertification and School Vehicle Attendants; and (6) revise reporting requirements of positive controlled substances or alcohol results.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. There will be a minimal fiscal impact on two local school systems and no fiscal impact on state agencies.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:		
	(E+)	$100
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	NONE	
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

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

C. In regard to the suggested change in COMAR 13A.06.07.09D(1), (School Vehicle Attendant Instruction), four LEAs (Caroline, Garrett, Somerset, and Worcester) do not currently meet the requirement. However, an increase in the required preservice instruction from 2- to 4-hours would have a minimal economic impact on only one county (Caroline), because their candidates are currently paid for training while the other three counties, Garrett, Somerset, and Worcester, do not pay for training. Caroline County Transportation Directors estimated the annual economic impact to be less than $100.

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 Patricia Askew, Staff Specialist, Maryland State Department of Education, Office of Pupil Transportation, 200 West Baltimore Street, Baltimore, Maryland 21201, or call 410-767-0217 (TTY 410-333-6442), or email to patricia.askew@maryland.gov, or fax to 410-333-2232. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

Open Meeting

Final action on the proposal will be considered by the State Board of Education during a public meeting to be held on February 28, 2017, 9:00 a.m., at 200 West Baltimore Street, Baltimore, Maryland 21201.

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) — (2) (text unchanged)

(3) "Appreciable damage" means property damage in excess of **[**$1,500**]** *$3,000*.

(4) — (21) (text unchanged)

(22) "School vehicle attendant" means and individual who:

(a) Has applied for employment with a local school system or an entity contracting with a local school system as a school vehicle attendant;

(b) Is employed by a school system or an entity contracting with a local school system as a school vehicle attendant; and

(c) Is certified and verified by the local school system as having met all local and state requirements to be a school vehicle attendant.

[(22)**]** *(23)* "School vehicle driver" means an individual who:

(a) — (b) (text unchanged)

(c) Is an owner-operator of a school vehicle**[**.**]***; and*

(d) Is certified and verified by the local school system as having met all local, state, and federal requirements to be a school vehicle driver.

[(23)**]** *(24)* "School vehicle driver trainee" means an individual who has applied for employment with a *local* school system *or an entity contracting with a school system* and is seeking Department-required certification as a school vehicle driver.

[(24)**]** *(25)* — **[**(32)**]** *(33)* (text unchanged)

.08 School Vehicle Attendant Qualifications and Disqualifications.

A. (text unchanged)

B. Disqualifications for Criminal Conduct.

(1) — (2) (text unchanged)

(3) An individual who pleads guilty or nolo contendere with respect to, is placed on probation before judgment with respect to, or is convicted of **[**an alcohol or**]** *a* controlled substance offense as defined in federal or State law is disqualified from serving as a school vehicle attendant for a period of 10 years from the date of the action.

C. — D. (text unchanged)

.09 Instructional Content Requirements.

A. Preservice Instruction for School Vehicle Drivers.

(1) A trainee shall satisfactorily complete a minimum of **[**6**]** *8* hours of classroom instruction in the core units of the school bus driver instructional program developed by the Department, including:

(a) — (c) (text unchanged)

(2) — (4) (text unchanged)

B. (text unchanged)

C. School Vehicle Driver Recertification.

(1) — (2) (text unchanged)

(3) If a school vehicle driver has been deleted from the school system's driver roster for more than 1 year, the school vehicle driver shall complete **[**preservice instruction as required under Regulation .09A**]** *all school vehicle trainee qualifications as required under Regulation .06A* of this chapter.

D. School Vehicle Attendant Instruction.

(1) Preservice Instruction. Before riding in the capacity of a school vehicle attendant on a school vehicle with students on board, a school vehicle attendant shall complete a minimum of **[**2**]** *4* hours of preservice instruction that includes:

(a) — (b) (text unchanged)

(2) (text unchanged)

E. (text unchanged)

.10 Alcohol and Controlled Substances Use and Testing.

A. — B. (text unchanged)

C. Reporting Disqualified Drivers.

(1) The supervisor of transportation shall notify the Department's Office of Pupil Transportation within 3 *business* days of receipt of positive controlled substances or alcohol test results.

(2) — (5) (text unchanged)
D. — F. (text unchanged)

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Subtitle 12 CERTIFICATION

13A.12.04 Administrators and Supervisors

Authority: Education Article, §§2-205, 2-303(g), and 6-701—6-705, Annotated Code of Maryland

Notice of Proposed Action

[16-343-P]

The Professional Standards and Teacher Education Board proposes to amend Regulation **.04** under **COMAR 13A.12.04 Administrators and Supervisors**. This action was considered by the Professional Standards and Teacher Education Board at their meeting on May 5, 2016 and the Maryland State Board of Education at their meeting on October 25, 2016.

Statement of Purpose

The purpose of this action is to align the regulatory language to reflect the current Professional Standards for Educational Leaders.

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 Sarah Spross, Assistant State Superintendent, Division of Educator Effectiveness, Maryland State Department of Education, 200 West Baltimore Street, Baltimore, Maryland 21201, or call 410-767-0385 (TTY 410-333-6442), or email to sarah.spross@maryland.gov, or fax to 410-333-8963. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

Open Meeting

Final action on the proposal will be considered by the Professional Standards and Teacher Education Board during a public meeting to be held on March 2, 2017, 9:30 a.m., at 200 West Baltimore Street, Baltimore, Maryland 21201.

.04 Supervisors of Instruction, Assistant Principals, and Principals.

A. (text unchanged)
B. Administrator I.
(1) — (2) (text unchanged)
(3) Completed one of the following:
(a) A Department-approved program which leads to certification as a supervisor of instruction, assistant principal, or principal that includes the **[**outcomes in the Maryland instructional leadership framework**]** *Professional Standards for Educational Leaders*;
(b) — (c) (text unchanged)
C. — D. (text unchanged)

KAREN B. SALMON, Ph.D.
State Superintendent of Schools

Title 13B MARYLAND HIGHER EDUCATION COMMISSION

Subtitle 06 GENERAL EDUCATION AND TRANSFER

13B.06.01 Public Institutions of Higher Education

Authority: Education Article, §§11-105(u) and 11-207, Annotated Code of Maryland

Notice of Proposed Action

[16-352-P]

The Maryland Higher Education Commission proposes to amend Regulations **.02**, **.02-1**, repeal existing Regulations **.04** and **.05** and adopt new Regulation **.04**, amend and recodify existing Regulations **.06—.08** to be Regulations **.05—.07**, and recodify existing Regulations **.09** and **.10** to be Regulations **.08** and **.09** under **COMAR 13B.06.01 Public Institutions of Higher Education**. This action was considered by the Maryland Higher Education Commission at a public meeting on November 16, 2016.

Statement of Purpose

The purpose of this action is to implement the provisions of Education Article, §11-207, Annotated Code of Maryland, concerning the transfer and reverse transfer of credits between and among Maryland 4-year and 2-year public institutions of higher education.

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 Dr. Emily Dow, Assistant Secretary, Maryland Higher Education Commission, 6 North Liberty Street 10th Floor, or call 410-767-3041, or email to emily.dow@maryland.gov. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

.02 Definitions.

A. (text unchanged)
B. Terms Defined.
(1)—(2) (text unchanged)
(3) "A.A.T. degree" means the Associate of Arts in Teaching degree.
(4) "A.F.A. degree" means the Associate of Fine Arts degree.
[(3)**]** *(5)* "Arts" means courses that examine aesthetics and the development of the aesthetic form and explore the relationship between theory and practice. **[**Courses in this area may include fine arts, performing and studio arts, appreciation of the arts, and history of the arts.**]**
[(4)**]** *(6)* (text unchanged)

(7) "A.S.E. degree" means the Associate of Science in Engineering degree.

(8) "Associate's degree" includes an:

(a) A.A. degree;

(b) A.S. degree;

(c) A.A.S. degree;

(d)A.A.T. degree;

(e) A.F.A. degree; and

(f) A.S.E degree.

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

(10) "Cumulative grade point average" means the average of grades received for completed coursework at all institutions attended.

[(6)**]** *(11)*—**[**(8)**]** *(13)* (text unchanged)

[(9)**]** *(14)* "Humanities" means courses that examine the values and cultural heritage that establish the framework for inquiry into the meaning of life. **[**Courses in the humanities may include the language, history, literature, and philosophy of Western and other cultures.**]**

[(10)**]** *(15)*— **[**(11)**]** *(16)* (text unchanged)

[(12)**]** *(17)* "Parallel program" means the program of study or courses at one institution of higher education **[**which**]** *that* has *parallel courses and* comparable objectives as those at another higher education institution, for example, a transfer program in psychology in a community college is definable as a parallel program to a baccalaureate psychology program at a 4-year institution of higher education.

[(13)**]** *(18)* (text unchanged)

[(14)**]** *(19)* "Recommended transfer program" means a planned program of courses, both general education and courses in the major, taken at a community college, which is applicable to a baccalaureate program at a receiving institution, and ordinarily the first **[**2 years**]** *half* of the baccalaureate degree.

*(20) "Reverse transfer" means a process whereby credits that a student earns at any public senior higher education institution in the State toward a bachelor's degree are transferrable to any community college in the State for credit toward an associate's degree***.**

[(15)**]** *(21)* (text unchanged)

[(16)**]** *(22)* "Social and behavioral sciences" means courses that **[**examine the psychology of individuals and the ways in which individuals, groups, or segments of society behave, function, and influence one another**]** *are concerned with the examination of society and the relationships among individuals within a society*. **[**The courses include, but are not limited to, subjects which focus on:

(a) History and cultural diversity;

(b) Concepts of groups, work, and political systems;

(c) Applications of qualitative and quantitative data to social issues; and

(d) Interdependence of individuals, society, and the physical environment.**]**

[(17)**]** *(23)* "Transfer student" means a student entering an institution for the first time having successfully completed a minimum of 12 semester hours at another institution [which is] *that are* applicable for credit at the institution the student is entering.

.02-1 Admission of Transfer Students to Public Institutions.

A. Admission to Institutions.

(1) **[**A**]** *Subject to §B of this regulation, a* student attending a public institution who has completed an **[**A.A., A.A.S., or A.S.**]** *associate's* degree or who has completed **[**56**]** *60* or more semester hours of credit, may not be denied direct transfer to another public institution if the student attained a cumulative grade point average of at least 2.0 on a 4.0 scale or its *equivalent at the sending institution* **[**in parallel courses**]**, except as provided in §A(4) of this regulation.

(2) **[**A**]** *Subject to §B of this regulation, a* student attending a public institution who has not completed an **[**A.A., A.A.S., or A.S.**]** *associate's* degree or who has completed fewer than **[**56**]** *60* semester hours of credit, is eligible to transfer to a public institution regardless of the number of credit hours earned if the student:

(a) (text unchanged)

(b) Attained at least a cumulative grade point average of 2.0 on a 4.0 scale or its equivalent *at the sending institution* **[**in parallel courses**]**.

(3) **[**A**]** *Subject to §B of this regulation, a* student attending a public institution who did not satisfy the admission criteria of a receiving public institution as a high school senior, but who has earned sufficient credits at a public institution to be classified by the receiving public institution as a sophomore, shall meet the stated admission criteria developed and published by the receiving public institution for transfer.

(4) If the number of students seeking admission exceeds the number that can be accommodated at a receiving public institution, admission decisions shall be:

(a) Based on criteria developed and published by the receiving public institution *on the institution's website*; and

(b) (text unchanged)

B. Admission to Programs.

(1) A receiving public institution may require **[**higher performance standards for admission**]** *additional program admission requirements* to some programs if the standards and criteria for admission to the program:

(a)—(b) (text unchanged)

[(2) If the number of students seeking admission exceeds the number that can be accommodated in a particular professional or specialized program, admission decisions shall be:

(a) Based on criteria developed and published by the receiving public institution; and

(b) Made to provide fair and equal treatment for native and transfer students.**]**

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

C. Receiving Institution Program Responsibility.

(1)—(3) (text unchanged)

(4) A receiving public institution shall ensure that any changes to program standards and criteria for admission and the transfer of credits maintain the fair and equal treatment of native and transfer students, and are communicated in a timely manner.

.04 Transfer of Education Program Credit.

A. Transfer of Credit to Another Public Institution.

(1) Credit earned at any public institution in the State is transferable to any other public institution if the:

(a) Credit is from a college or university parallel course or program;

(b) Grades in the block of courses transferred average 2.0 or higher; and

(c) Acceptance of the credit is consistent with the policies of the receiving institution governing native students following the same program.

(2) If a native student's "D" grade in a specific course is acceptable in a program, then a "D" earned by a transfer student in the same course at a sending institution is also acceptable in the program. Conversely, if a native student is required to earn a grade of "C" or better in a required course, the transfer student shall also be required to earn a grade of "C" or better to meet the same requirement.

B. Credit Earned in or Transferred From a Community College.

(1) Except as provided in §B(5) of this regulation, at least 60 credits but not more than 70 credits of general education, elective, and major courses that a student earns at any community college in

the State toward an associate's of art or an associate's of science degree shall be transferrable to any public senior higher education institution in the State for credit toward a bachelor's degree.

(2) To be transferrable, a credit shall have been earned in accordance with the student's degree plan.

(3) Courses taken at a public institution as part of a recommended transfer program leading toward a baccalaureate degree shall be applicable to related programs at the receiving public institution granting the degree if successfully completed in accordance with the receiving institution's policies governing native students in the same program.

(4) Students earning an A.A.S. or A.F.A. degree shall have their credits evaluated in a manner that maximizes the transfer of articulated and elective credit.

(5) A community college and a public senior higher education institution may provide in an articulation agreement for the transfer of credits in addition to credits transferred under §B(1) of this regulation.

C. Nontraditional Credit.

(1) The assignment of credit for AP, CLEP, or other nationally recognized standardized examination scores presented by transfer students is determined according to the same standards that apply to native students in the receiving institution, and the assignment shall be consistent with the State minimum requirements.

(2) Transfer of credit from the following areas shall be consistent with COMAR 13B.02.02. and shall be evaluated by the receiving institution on a course-by-course basis according to the same standards that apply to native students at the receiving institution:

(a) Technical courses from career programs;

(b) Course credit awarded through articulation agreements with other segments or agencies, which should be developed in collaboration with all public institutions, including course credit awarded by articulation with Maryland public secondary schools;

(c) Credit awarded for clinical practice or cooperative education experiences;

(d) Credit awarded for life and work experiences; and

(e) Credit awarded for training, coursework, or education through the military.

(3) The basis for the awarding of the credit shall be indicated on the student's transcript by the receiving institution.

(4) The receiving institution shall inform a transfer student of the procedures for validation of course work for which there is no clear equivalency. Examples of validation procedures include ACE recommendations, portfolio assessment, credit through challenge, examinations, and satisfactory completion of the next course in sequence in the academic area.

(5) The receiving baccalaureate degree-granting institution shall use validation procedures when a transferring student successfully completes a course at the lower-division level that the receiving institution offers at the upper-division level. The validated credits earned for the course shall be substituted for the upper-division course.

D. Program Articulation.

(1) Recommended transfer programs shall be developed through collaboration between the sending and receiving institutions. A recommended transfer program represents an agreement between the two institutions that allows students aspiring to the baccalaureate degree to plan for seamless transfer. These programs constitute freshman/sophomore level course work to be taken at the community college in fulfillment of the receiving institution's lower division course work requirement.

(2) Recommended transfer programs in effect at the time that this regulation takes effect, which conform to this chapter, may be retained.

E. Reverse Transfer of Credit

(1) Subject to paragraph (2) of this section, a community college shall accept for reverse transfer any credits that an individual earned at a public senior institution up to 45 credits. Credits in excess of 45 credits may be accepted in accordance with the community college's policy.

(2) To be eligible for the transfer of credit under paragraph (1) of this section, a student shall have completed at least 15 credits at the community college to which the credits are transferred.

(3) Community colleges and public senior institutions shall develop a process to identify students eligible for reverse transfer at no cost to the student.

F. Transfer of General Education Credit

(1) A student transferring to one public institution from another public institution shall receive general education credit for work completed at the student's sending institution as provided by this chapter.

(2) A completed general education program shall transfer without further review or approval by the receiving institution and without the need for a course-by-course match.

(3) Courses that are defined as general education by one institution shall transfer as general education even if the receiving institution does not have that specific course or has not designated that course as general education.

(4) A Maryland community college shall accept 28 - 36 credits of general education as specified in § C of Regulation .03 of this chapter as completion of the general education requirements at the community college, without further review or the need for a course-by-course match.

(5) The receiving institution shall give lower-division general education credits to a transferring student who has taken any part of the lower-division general education credits described in Regulation .03 of this chapter at a public institution for any general education courses successfully completed at the sending institution.

(6) Except as provided in Regulation .03M of this chapter, a receiving institution may not require a transfer student who has completed the requisite number of general education credits at any public college or university to take, as a condition of graduation, more than 10--18 additional semester hours of general education and specific courses required of all students at the receiving institution, with the total number not to exceed 46 semester hours. This provision does not relieve students of the obligation to complete specific academic program requirements or course prerequisites required by a receiving institution.

(7) Each public institution shall designate on or with the student transcript those courses that have met its general education requirements, as well as indicate whether the student has completed the general education program.

(8) Associate's Degrees.

(a) While there may be variance in the numbers of hours of general education required for associate's degrees at a given institution, the courses identified as meeting general education requirements for all degrees shall come from the same general education course list and exclude technical or career courses.

(b) A student possessing an associate's degree who transfers into a receiving institution with fewer than the total number of general education credits designated by the receiving institution shall complete the difference in credits according to the distribution as designated by the receiving institution. Except as provided in § M of regulation .03 of this chapter, the total general education credits for baccalaureate degree-granting public receiving institutions may not exceed 46 credits.

(9) Student Responsibilities. A student is held:

(a) Accountable for the loss of credits that:

(i) Result from changes in the student's selection of the major program of study,

(ii) Were earned for remedial course work, or

(iii) Exceed the total course credits accepted in transfer as allowed by this chapter; and

(b) Responsible for meeting all requirements of the academic program of the receiving institution.

[**.06**] ***.05*** **Academic Success and General Well-Being of Transfer Students.**

A. Sending Institutions.

(1) Community colleges shall encourage their students to complete the associate degree **[**or to complete 56 hours**]** in a recommended transfer program **[**which**]** *that* includes both general education courses and courses applicable toward the program at the receiving institution.

(2) (text unchanged)

(3) The sending institution shall:

(a) Provide to community college students information about the specific transferability of courses *and* programs **[**at**]** *to* 4-year colleges;

(b)—(c) (text unchanged)

B. Receiving Institutions.

(1)—(2) (text unchanged)

(3) A receiving institution shall evaluate the transcript *or transcripts* of a degree-seeking transfer student as expeditiously as possible, and notify the student of the results **[**not later than mid-semester of the student's first semester of enrollment at the receiving institution, if all official transcripts have been received at least**]** *within* **[**15**]** *20* working days **[**before mid-semester**]** *of the receipt of all official transcripts*. The receiving institution shall inform a student of the courses **[**which**]** *that* are acceptable for transfer credit and the courses **[**which**]** *that* are applicable to the student's intended program of study.

(4) **[**A receiving institution shall give a transfer student the option of satisfying institutional graduation requirements that were in effect at the receiving institution at the time the student enrolled as a freshman at the sending institution. In the case of major requirements, a transfer student may satisfy the major requirements in effect at the time when the student was identifiable as pursuing the recommended transfer program at the sending institution. These conditions are applicable to a student who has been continuously enrolled at the sending institution.**]** *A transfer student shall be provided the same opportunity as a native student to pursue the program and degree requirements that were in effect at the time that the student enrolled at the sending institution provided they have been continuously enrolled and otherwise meet the same requirements of the native student.*

[**.07**] ***.06*** **Programmatic Currency.**

A. **[**A receiving institution**]** *Maryland public institutions* shall **[**provide**]** *collaborate* **[**to the community college**]** *to develop and provide to students* current and accurate information on **[**recommended transfer**]** *transferable* programs and **[**the transferability status of courses. Community college students shall have access to this information**]** *courses*.

B. *Upon approval of new baccalaureate programs,* **[**Recommended**]** *recommended* transfer programs shall be developed with each community college **[**whenever new baccalaureate programs are approved by the degree-granting institution**]**.

C. (text unchanged)

[**.08**] ***.07*** **Transfer Mediation Committee.**

A. **[**There is a Transfer Mediation Committee, appointed by**]** *Sending and receiving institutions that disagree on the transferability of general education courses as defined by this chapter shall submit their disagreements to* the Secretary, *who shall appoint a Transfer Mediation Committee to adjudicate the disagreement. Members appointed to the Transfer Mediation Committee* **[**which is**]** *shall be* representative of the public 4-year colleges and universities and the community colleges.

[B. Sending and receiving institutions that disagree on the transferability of general education courses as defined by this chapter shall submit their disagreements to the Transfer Mediation Committee. The Transfer Mediation Committee shall address general questions regarding existing or past courses only, not individual student cases, and shall also address questions raised by institutions about the acceptability of new general education courses. As appropriate, the Committee shall consult with faculty on curricular issues.**]**

B. The Transfer Mediation Committee shall address general education issues at the course or curricular level, not individual student cases. As appropriate, the Committee shall consult with faculty on curricular issues.

C. (text unchanged)

JAMES D. FIELDER, JR., Ph.D.
Secretary of Higher Education

Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 03 INSURANCE PRODUCERS AND OTHER INSURANCE PROFESSIONALS

31.03.06 Surplus Lines

Authority: Insurance Article, §§2-109, 3-304, 3-306, 3-307, 3-311—3-313, 3-325(c), 9-301(f), 9-303(5), 9-401(i)(l), and 9-405(b), Annotated Code of Maryland

Notice of Proposed Action

[16-350-P]

The Insurance Commissioner proposes to amend Regulation **.10** under **COMAR 31.03.06 Surplus Lines**.

Statement of Purpose

The purpose of this action is to add short-term homeshare business multi-peril insurance to the exportable list. This coverage is presently not available on the admitted market to all applicants.

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 Catherine Grason, Director of Regulatory Affairs, Maryland Insurance Administration, 200 St. Paul Place, Ste. 2700, Baltimore, MD 21202, or call 410-468-2201, or email to insuranceregreview.mia@maryland.gov, or fax to 410-468-2020. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

.10 Surplus Lines Exportable List.

A.—B. (text unchanged)

C. The surplus lines exportable list is as follows:

(1)—(38) (text unchanged)

(39) Short-term homeshare business multi-peril;

[(39)**]** *(40)*—**[**(49)**]** *(50)* (text unchanged)

ALFRED W. REDMER, JR.
Insurance Commissioner

Subtitle 14 LONG-TERM CARE

Notice of Proposed Action

[16-348-P]

The Insurance Commissioner proposes to:

(1) Amend Regulations **.13**, **.24**, and **.36** under **COMAR 31.14.01 Long-Term Care Insurance**; and

(2) Amend Regulations **.03—.06** and adopt new Regulation **.06-1** under **COMAR 31.14.02 Long-Term Care Insurance—Premium Rates and Reserves**.

Statement of Purpose

The purpose of this action is to update these regulations consistent with 2014 changes to the National Association of Insurance Commissioners' "Long-Term Care Model Regulation" (Model 641). These amendments do the following to mitigate large long-term care rate increases for consumers:

(1) Define a minimum composite moderately adverse experience (MAE) margin of 10% to encourage more conservative pricing.

(2) Require the insurer to submit an annual actuarial certification regarding the sufficiency of the current premium rate structure, which encourages an insurer to file a rate increase when needed, rather than delay which leads to requests of larger rate increases later.

(3) Require the insurer to replace the "58" in the current 58/85 loss ratio test for rate increases with the greater of 58 percent and the original lifetime loss ratio with the moderately adverse margin specified in the initial filing. For insurers that price at a loss ratio greater than 58 percent, this change makes it more difficult for the insurer to pass the loss ratio test. This change maintains the portion of original premiums to be used for benefits plus the higher portion of any rate increase in rate increase filings.

(4) Strengthen consumer disclosure requirements at the time of a rate increase.

(5) Reduce contingent nonforfeiture benefit triggers for older policies, and lower the rate increase trigger to 100 percent for policyholders with issue ages of 54 and younger. These changes provide greater value to any consumer who decides to lapse a long-term care policy following a rate increase.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. This regulation will impact consumer rates for long-term care insurance.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:		
Limits to rate increases	(-)	Unknown
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:		
Premium savings	(+)	Unknown

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

D. These regulations decrease the dollar amount of rate increases that a carrier may submit on existing long-term care insurance policies.

F. Consumers with existing long-term care policies will be subjected to lower rate increases than under the previous regulations, potentially saving them premium dollars.

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 Lisa Larson, Assistant Director of Regulatory Affairs, Maryland Insurance Administration, 200 Saint Paul Place, Ste. 2700, Baltimore, Maryland 21202, or call 410-468-2007, or email to insuranceregreview.mia@maryland.gov, or fax to 410-468-2020. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

31.14.01 Long-Term Care Insurance

Authority: Health-General Article, §19-705; Insurance Article, §§2-109, 14-124, Title 18, Subtitle 1, and Title 27; Annotated Code of Maryland

.13 Nonforfeiture Benefit Requirement.

A.—D. (text unchanged)

E. Contingent Benefit Upon Lapse Provision.

(1)—(6) (text unchanged)

(7) On or before the effective date of a substantial premium increase as described in §E(3) and (5) of this regulation, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage **[**without the requirement of additional underwriting**]** *consistent with the requirements of Regulation .36 of this chapter* so that required premium payments are not increased;

(b)—(c) (text unchanged)

(8) (text unchanged)

(9) On or before the effective date of a substantial premium increase as described in §E(6)(a) and (c) of this regulation, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage **[**without the requirement of additional underwriting**]** *consistent with the requirements of Regulation .36 of this chapter* so that required premium payments are not increased;

(b)—(c) (text unchanged)

(10)—(11) (text unchanged)

(12) For any long-term care policy issued in Maryland on or after September 1, 2017:

(a) If the policy or certificate was issued at least 20 years before the effective date of the increase, a value of 0 percent shall be used in place of all values in the table in §E(6)(c) of this regulation; and

(b) Values above 100 percent in the table in §E(5) of this regulation shall be reduced to 100 percent.

F.—K. (text unchanged)

.24 Reporting Requirements.

A.—G. (text unchanged)

H. Annual Rate Certification Requirements for Rate Schedules Currently Marketed.

(1) This section applies to any long-term care policy issued in Maryland on or after September 1, 2017 that is currently marketed.

(2) An insurer shall submit an annual actuarial certification to the Commissioner in accordance with the following conditions:

(a) The certification shall be prepared, dated, and signed by a member of the American Academy of Actuaries;

(b) The certification shall contain one of the following conclusions:

(i) The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience, and is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or

(ii) Margins for moderately adverse experience may no longer be sufficient;

(c) The certification shall be based on calendar year data;

(d) The certification shall be submitted annually not later than May 1 of each year starting in the second year following the year in which the initial rate schedules are first used;

(e) The certification shall contain a description of the review performed that led to the applicable conclusion in §H(2)(b) of this regulation; and

(f) If the certification contains the conclusion set forth in §H(2)(b)(ii) of this regulation, the insurer shall provide to the Commissioner a plan of action subject to the following conditions:

(i) The plan shall be submitted within 60 days of the date the actuarial certification is submitted; and

(ii) The plan shall include a time frame for the reestablishment of adequate margins for moderately adverse experience such that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated.

(3) Failure to comply with §H(2)(f) of this regulation constitutes grounds for the Commissioner to withdraw or modify approval of a form for future sales under Insurance Article, §12-205, Annotated Code of Maryland.

I. Annual Rate Certification Requirements for Rate Schedules That are No Longer Marketed.

(1) This section applies to any long-term care policy issued in Maryland on or after September 1, 2017 that is no longer marketed.

(2) An insurer shall submit an annual actuarial certification to the Commissioner in accordance with the following conditions:

(a) The certification shall be prepared, dated, and signed by a member of the American Academy of Actuaries;

(b) The certification shall contain one of the following conclusions:

(i) The premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

(ii) The premium rate schedule may no longer be sufficient;

(c) The certification shall be based on calendar year data;

(d) The certification shall be submitted annually not later than May 1 of each year starting in the second year following the year in which the initial rate schedules are first used;

(e) The certification shall contain a description of the review performed that led to the applicable certification or statement in §I(2)(b) of this regulation.

(f) If the certification contains the conclusion set forth in §I(2)(b)(ii) if this regulation, the insurer shall provide to the Commissioner a plan of action subject to the following conditions:

(i) The plan shall be submitted within 60 days of the date the actuarial certification is submitted; and

(ii) The plan shall include a time frame for the reestablishment of adequate margins for moderately adverse experience.

J. Actuarial Memorandum.

(1) An actuarial memorandum to support the actuarial certifications required by §§H and I of this regulation shall be submitted as follows:

(a) The actuarial memorandum shall be dated and signed by the member of the American Academy of Actuaries who prepares the actuarial certification;

(b) The actuarial memorandum shall be submitted at least once every 3 years with the certification;

(c) The actuarial memorandum shall contain at least the following information:

(i) A detailed explanation of the data sources and review performed by the actuary before drawing the appropriate conclusion in §H(2)(b) or §I(2)(b) of this regulation;

(ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions;

(iii) A description of the credibility of the experience data; and

(iv) An explanation of the analysis and testing performed in determining the current presence of margins.

.36 Right to Reduce Coverage and Lower Premiums.

A. Unless otherwise specified, the requirements of this regulation shall apply to any long-term care policy issued in Maryland on or after September 10, 2008.

[A.**]***B.* Required Provision in Long-Term Care Insurance Policies and Certificates.

(1) (text unchanged)

(2) An insurer may also offer reduction options other than those described in **[**§A(1)**]** *§B(1)* of this regulation, if the reduction options are consistent with the policy or certificate design or the insurer's administrative processes.

(3) For any long-term care policy issued in Maryland on or after March 1, 2018, if the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

[B.**]** *C.* The provision required by **[**§A**]** *§B* of this regulation shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

[C.**]** *D. Premium for Reduced Coverage.*

(1) The age used to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(2) For any long-term care policy issued in Maryland on or after March 1, 2018, the premium for the reduced coverage shall:

(a) Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

(b) Be consistent with the approved rate table.

[D.**]** *E.*—**[**F.**]** *G.* (text unchanged)

[G. The requirements of this regulation shall apply to any long-term care policy issued in Maryland on or after September 10, 2008.**]**

31.14.02 Long-Term Care Insurance—Premium Rates and Reserves

Authority: Health-General Article, §19-705; Insurance Article, §§2-109, 14-124, Title 18, Subtitle 1, and Title 27; Annotated Code of Maryland

.03 Required Disclosure of Rating Practices to Consumers.

A. Applicability.

(1) Except as provided in §A(2) *and (3)* of this regulation, the provisions of this regulation apply to any long-term care policy or certificate issued in this State on or after October 1, 2002.

(2) For certificates issued on or after April 1, 2002, under an employer group long-term care insurance policy that was in force on April 1, 2002, the provisions of this regulation apply on the policy anniversary following April 1, 2003.

(3) The requirements of §K(2)(ii)-(iv) of this regulation shall apply to any rate increase implemented in Maryland on or after March 1, 2018.

B.—C. (text unchanged)

D. The insurer shall provide the following information to the applicant in accordance with §§B and C of this regulation:

(1) (text unchanged)

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's **[**option**]** *options* in the event of a premium rate revision, *including the options described in §B of COMAR 31.14.01.36*; *and applicable disclosures described in §K(2)(iii) and (iv) of this regulation.*

(3)—(5) (text unchanged)

E.—J. (text unchanged)

K. Notice of Premium Rate Schedule Increase.

(1) (text unchanged)

(2) A notice shall include **[**the information required by §D of this regulation when a rate increase is implemented.**]***:*

(i) The information required by §D of this regulation when a rate increase is implemented;

(ii) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of COMAR 31.14.01.36;

(iii) A disclosure stating that all options available to the policyholder may not be of equal value; and

(iv) In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

.04 Initial Filing Requirements.

A. *Applicability.*

(1) Sections B.-D. of **[**This**]** *this* regulation [applies] *apply* to any long-term care policy issued in Maryland on or after October 1, 2002 *and before September 1, 2017.*

(2) Sections E.—H. of this regulation apply to any to any long-term care policy issued in Maryland on or after September 1, 2017.

B.—D. (text unchanged)

E. An insurer shall provide the following information to the Commissioner at least 60 days before making a long-term care insurance form available for sale:

(1) A copy of the disclosure documents required by Regulation .03 of this chapter;

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A statement that the premiums contain one of the following:

(i) At least the minimum composite margin for moderately adverse experience as specified in §G(1) of this regulation; or

(ii) The specification of and justification for a lower margin as required by §G(2) of this regulation; and

(e) One of the following:

(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences;

(f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:

(i) Sufficient detail or sample calculations to provide a complete depiction of the reserve amounts to be held; and

(ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; and

(g) If the statement required in §E(2)(f)(ii) of this regulation cannot be made, a complete description of the circumstances under which this does not occur; and

(3) An actuarial memorandum prepared, dated and signed by a member of the American Academy of Actuaries that:

(a) Addresses and supports each specific item required as part of the actuarial certification;

(b) Provides at least the following information:

(i) An explanation of the review performed by the actuary before making the statements in §E(2)(b) and (c) of this regulation;

(ii) A complete description of pricing assumptions;

(iii) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement made in the actuarial certification under §E(2)(a) of this regulation;

(iv) An explanation of the analysis and testing performed in determining the sufficiency of the margins provided for in §E(2)(d) of this regulation, to include a clear description of the deviations in margins between ages, sexes, plans or states other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales; and

(v) A demonstration that the gross premiums include the minimum composite margin specified in §E(2)(d) of this regulation.

F. In providing the statement required by §E(2)(f)(ii) of this regulation, the insurer may base this statement on the following:

(1) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; or

(2) If the gross premiums for certain age groups appear to be inconsistent with the requirement in §E(2)(f)(ii) of this regulation, the Commissioner may request a demonstration under §H of this regulation based on a standard age distribution.

G. The following provisions apply to the statement required under §E(2)(d) of this regulation:

(1) For the purposes of the actuarial certification under §E(2)(d)(i) of this regulation, a composite margin may not be less than 10 percent of lifetime claims;

(2) For the purposes of the actuarial certification under §E(2)(d)(ii) of this regulation, a composite margin less than 10 percent may be justified in uncommon circumstances, if the following is submitted:

(a) Full justification of the proposed amount; and

(b) Methods to monitor developing experience that would be the basis for withdrawal of approval for the lower margins;

(3) A composite margin lower than otherwise considered appropriate for the standalone long-term care policy may be justified for long-term care benefits if it is:

(a)Provided through a life insurance policy or an annuity contract; and

(b)The lower composite margin is justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product; and

(4) A greater margin may be appropriate if the insurer has less credible experience to support its assumptions used to determine the premium rates.

H. Additional Information.

(1) In any review of the actuarial certification and actuarial memorandum required by §E of this regulation, the Commissioner may request review by an independent actuary with experience in long-term care pricing.

(2) If the Commissioner asks for additional information under this section, the period in §E of this regulation does not include the period during which the insurer is preparing the requested information.

.05 Loss Ratio.

A. This regulation applies to all long-term care insurance policies or certificates except those covered under Regulations .04, **[**and**]** .06, *and .06-1* of this chapter.

B.—C. (text unchanged)

.06 Premium Rate Schedule Increases.

A. Applicability.

(1) Except as provided in §A(2) of this regulation, the provisions of this regulation apply to any long-term care policy or certificate issued in Maryland on or after October 1, 2002 *and before September 1, 2017*.

(2) For certificates issued on or after **[**the effective date of this amended regulation**]** *April 1, 2002*, under an employer group long-term care insurance policy that was in force on April 1, 2002, the provisions of this regulation apply on the policy anniversary following April 1, 2003.

B. Premium Rate Increase Filing Requirements.

(1) (text unchanged)

(2) The notice to the Commissioner required by §B(1) of this regulation shall include:

(a)—(b) (text unchanged)

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i)—(iv) (text unchanged)

(v) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; **[**and**]**

(vi) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, composite rates reflecting projections of new certificates; *and*

(vii) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Regulation .04B(2)(d) or .04E(2)(d) of this chapter is projected to be exhausted.

(d)—(e) (text unchanged)

(3) (text unchanged)

C. An insurer may request a premium rate schedule increase less than what is required under this regulation and the Commissioner may approve this premium rate schedule increase, without submission of the certification required under §B(2)(b)(i)of this regulation, if:

(1) The actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under §B(2)(b) of this regulation;

(2) The premium rate schedule increase filing satisfies all other requirements of §B of this regulation; and

(3) The premium rate schedule increase filing is, in the opinion of the Commissioner, in the best interest of policyholders.

[C.**]** *D.*—**[**K.**]** *L.* (text unchanged)

.06-1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings.

A. Applicability.

(1) Except as provided in §A(2) of this regulation, this regulation applies to any long-term care policy or certificate issued in Maryland on or after September 1, 2017.

(2) For certificates issued on or after the effective date of this amended regulation under an employer group long-term care insurance policy as defined in Regulation .02B(1) of this chapter if the policy was in force at the time this amended regulation became effective, the provisions of this regulation shall apply on the policy anniversary following March 1, 2018.

B. Premium Rate Increase Filing Requirements.

(1) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Commissioner at least 30 days before issuing the notice to the policyholders.

(2) The notice to the Commissioner required by §B(1) of this regulation shall include:

(a) Information required by Regulation .03 of this chapter;

(b) Certification by a qualified actuary that:

(i) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(ii) The premium rate filing is in compliance with the provisions of this regulation;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase;

(ii) The method and assumptions used in determining the lifetime projections described in §B(2)(c)(i) of this regulation, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(iii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit on lapse;

(iv) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer have been relied on by the actuary;

(v) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(vi) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

(e) Sufficient information for review and approval of the premium rate schedule increase by the Commissioner.

(3) The lifetime projection and assumptions required to be filed under §B(2)(c)(i) and (ii) of this regulation shall comply with the following requirements:

(a) Annual values for the 5 years preceding and the 3 years following the valuation date shall be provided separately;

(b) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(c) The projections shall demonstrate compliance with §C of this regulation; and

(d) For exceptional increases:

(i) The projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(ii) If the Commissioner determines as provided in Regulation .07C of this chapter that offsets may exist, the insurer shall use appropriate net projected experience.

(4) The insurer may request and the Commissioner may approve a premium rate schedule increase less than what is required under this regulation without submission of the certification in §B(2)(b)(i) of this regulation, if:

(a) The actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under §B(2)(b) of this regulation;

(b) The premium rate schedule increase filing satisfies all other requirements of this regulation; and

(c) The premium rate schedule is, in the opinion of the Commissioner, in the best interest of policyholders.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the lesser of the accumulated value of actual incurred claims, without the inclusion of active life reserves, or the accumulated value of historic expected claims, with the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times 58 percent;

(b) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times 58 percent; and

(d) 85 percent of the present value of future projected premiums not in §C(2)(c) of this regulation on an earned basis;

(3) Expected claims shall be calculated as follows:

(a) Original filing assumptions shall be assumed until new assumptions are filed as part of a rate increase;

(b) New assumptions shall be used for all periods beyond each requested effective date of a rate increase;

(c) For each calendar year, expected claims shall be based on in-force business at the beginning of the calendar year;

(d) Expected claims shall include margins for moderately adverse experience that are:

(i) Amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing; or

(ii) Amounts as modified in any rate increase filing.

(4) If a policy form has both exceptional and other increases, the values in §C(2)(b) and (d) shall also include 70 percent for exceptional rate increase amounts;

(5) All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in Regulation .13 of this chapter; and

(6) The actuary shall disclose as a part of the actuarial memorandum the use of any appropriate averages.

D. Updated Projections.

(1) For each rate increase that is implemented, the insurer shall file for approval by the Commissioner updated projections, as described in §B(2)(c)(i) and (ii) of this regulation, annually for the next 3 years and include a comparison of actual results to projected values.

(2) The Commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections.

(3) For group insurance policies that meet the conditions in §K of this regulation, the projections required by this section shall be provided to the policyholder instead of filing with the Commissioner.

E. Lifetime Projections.

(1) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as described in §B(2)(c)(i) and (ii) of this regulation, shall be filed for approval by the Commissioner every 5 years following the end of the required period in §D of this regulation.

(2) For group insurance policies that meet the conditions in §L of this regulation, the projections required by this section shall be provided to the policyholder instead of filing with the Commissioner.

F. Commissioner's Authority if Actual Experience Does Not Match Projected Experience.

(1) If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in §C of this regulation, the Commissioner may require the insurer to implement any of the following:

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches the projected experience, consideration shall be given to §B(2)(c)(vi) of this regulation, if applicable.

G. Filing Required if Rate Increase Causes Eligibility for Contingent Benefit.

(1) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to the Commissioner's approval, for improved administration;

(b) A plan, subject to the Commissioner's approval, for improved claims processing; or

(c) Both plans, if applicable.

(2) A plan filed in accordance with §G(1) of this regulation shall:

(a) Demonstrate that it is designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases; or

(b) Demonstrate that appropriate administration or claims processing, or both, has been implemented or is in effect.

(3) If the insurer fails to file a plan required by §G(1) of this regulation or fails to receive approval from the Commissioner of the plan filed under §G(1) of this regulation, the Commissioner may impose the requirements in §H of this regulation.

H. Lapse Rates.

(1) The Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated, if a rate increase filing meets the following criteria:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) If the Commissioner determines during the review described in §H(1) of this regulation that significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the *updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists.*

(3) If the Commissioner determines that a rate spiral exists as described in §H(2) of this regulation, the Commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(4) The offer required by §H(3) of this regulation shall:

(a) Be subject to the approval of the Commissioner;

(b) Be based on actuarially sound principles, but not be based on attained age; and

(c) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(5) Maintenance of Experience. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(a) The maximum rate increase determined based on the combined experience; and

(b) The maximum rate increase determined based only on the experience of insureds originally issued the form plus 10 percent.

I. If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of §H of this regulation, prohibit the insurer from:

(1) Filing and marketing comparable coverage for a period of up to 5 years;

(2) Offering all other similar coverages; or

(3) Limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Exemption for Incidental Coverage.

(1) Sections A—I of this regulation do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Regulation .02B(3) of this chapter, if the policy complies with all of the following requirements:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) The standard nonforfeiture requirements for life insurance found in Insurance Article, Title 16, Subtitle 3, Annotated Code of Maryland;

(ii) The standard nonforfeiture requirements for individual deferred annuities found in Insurance Article, Title 16, Subtitle 5, Annotated Code of Maryland; or

(iii) The requirements for variable annuities found in COMAR 31.09.04;

(c) The policy meets the disclosure requirements of Insurance Article, §§18-108 and 18-117, Annotated Code of Maryland;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(i) Policy illustrations for life insurance as required by COMAR 31.09.09;

(ii) Disclosure requirements for annuities as required by COMAR 31.15.04; and

(iii) Disclosure requirements for variable annuities as required by COMAR 31.09.04;

(e) An actuarial memorandum is filed with the Commissioner that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(2) For the expense assumptions used in §J(1)(e)(iv) of this regulation, an insurer shall include percent of premium dollars per policy and dollars per unit, if any.

(3) Contents of Statement on Underwriting.

(a) The statement required by §J(1)(e)(vii) of this regulation shall indicate whether underwriting is used.

(b) If underwriting is used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting.

(c) If coverage is under a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

K. Sections F and H of this regulation do not apply to employer group long-term care insurance if:

(1) The policies insure 250 or more individuals and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificate holders, pays a material portion of the premium, which may not be less than 20

percent of the total premium for the group in the calendar year before the year a rate increase is filed.

ALFRED W. REDMER, JR.
Insurance Commissioner

Title 35
MARYLAND DEPARTMENT OF VETERANS AFFAIRS

Subtitle 03 VETERANS CEMETERIES

35.03.01 Burial in State Veterans' Cemeteries

Authority: State Government Article, §9-906, Annotated Code of Maryland

Notice of Proposed Action

[16-357-P]

The Secretary of Veterans Affairs proposes amend Regulation **.05** under **COMAR 35.03.01 Burial in State Veterans' Cemeteries**.

Statement of Purpose

The purpose of this action is to define the cost of burial of a veteran's eligible dependent, and to establish the fee for burial of an eligible dependent to be equal to the burial plot allowance provided by the United States Department of Veterans Affairs for burial of a veteran in a State veterans' cemetery.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. By making the dependent burial fee equal to the U.S. Department of Veterans Affairs burial plot allowance for casketed or noncasketed burial of a veteran, eligible dependents will no longer pay a lower fee for a noncasketed burial than for a casketed burial.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:		
Increase in dependent burial fee	(R+)	$125,000 (FY 2018 estimated)
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	NONE	
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:		
Increase in dependent burial fee	(-)	$125,000 (estimated for FY 2018)

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

A. COMAR Title 35.03.01.05 currently establishes the dependent burial fee at $400 for a noncasketed burial and $600 plus the Department's cost of a liner and associated services for casketed remains. Upon implementation of the proposed changes, the dependent fee for both casketed and noncasketed burials will be equal to the U.S. Department of Veterans Affairs burial plot allowance, currently $749.00. There will be a resulting increase in revenue to the issuing agency as a result, primarily due to the change in fee for noncasketed dependent burials.

F. COMAR Title 35.03.01.05 currently establishes the dependent burial fee at $400 for a noncasketed burial and $600 plus the Department's cost of a liner and associated services for casketed remains. Upon implementation of the proposed changes, the dependent fee for both casketed and noncasketed burials will be equal to the U.S. Department of Veterans Affairs burial plot allowance, currently $749.00. There will be a resulting increase in the fee charged for the burial of an veteran's eligible dependent in a State veterans' cemetery, primarily due to the change in fee for noncasketed dependent burials.

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 Peter Pantzer, Director of Finance and Administration, Maryland Department of Veterans Affairs, 16 Francis St., 4th Fl., Annapolis, MD 21401, or call 410-260-3867, or email to peter.pantzer@maryland.gov, or fax to 410-216-7928. Comments will be accepted through January 23, 2017. A public hearing has not been scheduled.

.05 Burial in a State Veterans' Cemetery.

A. — B. (text unchanged)

[C. An eligible family member shall be buried in the plot assigned to the veteran after payment of the following fees:

(1) The actual cost to the Department for a grave liner and associated services for casketed remains;

(2) An opening and closing cost of $600 for casketed remains of each dependent spouse or spouses or dependent children; and

(3) An opening and closing cost of $400 for cremated remains of each dependent spouse or spouses or dependent children.

D. The Department may evaluate the opening and closing costs on a yearly basis and may adjust opening and closing costs not to exceed the Department's actual cost of the opening and closing.**]**

C. An eligible family member shall be buried in the plot assigned to the veteran after payment of the cost of burial, which shall be a sum equivalent to the amount of the burial plot allowance from the U.S. Department of Veterans Affairs, effective as of the date of death of the dependent, for burial of casketed or cremated remains of a veteran in a State veterans' cemetery.

[E.**]** *D.* — **[**I.**]** *H.* (text unchanged)

GEORGE W. OWINGS III
Secretary of Veterans Affairs

Errata

COMAR 10.43

At 43:20 Md. R. 1117 (September 30, 2016), column 1, lines 26 and 27 from the top:

For: (11) Recodify existing **COMAR 10.43.11** to be **COMAR 10.43.12**, amend chapter name, and amend Regulation **.02** under

Read: (11) Recodify existing **COMAR 10.43.12** to be **COMAR 10.43.11**, amend chapter name, and amend Regulation **.02** under

[16-26-34]

COMAR 10.65

At 43:20 Md. R. 1120 (September 30, 2016), column 1, line 30 from the top:

For: (a)—(d) (text unchanged)

Read: **[**(a)**]** *(1)*—[(d)] *(4)* (text unchanged)

[16-26-35]

Special Documents

DEPARTMENT OF THE ENVIRONMENT

FINAL CALENDAR YEAR 2017 STANDARD PERMIT APPLICATION TURNAROUND TIMES

As required by Section 1-607(A)(2) of the Environment Article, the Maryland Department of the Environment (MDE) has established, in consultation with interested parties, the following standard turnaround times for all types of permit applications.

MDE has made the following changes to the 2016 turnaround times for calendar year 2017.

Individual Composting Facility Permit – This is a new permit category with a turnaround time of 220 days.

General Composting Facility Permit – This is a new permit category with a turnaround time of 120 days.

These composting facility permits were created in response to legislation passed in 2013 and new composting facility regulations adopted in 2015. A composting facility that does not fall within a permit exemption under the composting regulations (COMAR 26.04.11) is required to obtain coverage under either the general or individual permit. The General Composting Facility Permit includes a single set of terms and conditions that are issued every 5 years. A facility that opts to follow all of these terms and conditions may seek coverage under the General Composting Facility Permit and undergo a shorter application and approval process. The more detailed Individual Composting Facility Permit option is available for facilities that wish to apply for site-specific permit conditions, including variances from the standard requirements.

Wet Storage of Shellfish – Wet storage means the storage, by a dealer, of market size oysters or clams from growing areas in the approved classification or in the open status of the conditionally approved classification in containers or floats in natural bodies of water or in tanks containing natural seawater at any permitted land-based activity or facility. Only certified dealers can be authorized for wet storage. The turnaround time for these permits is 30 days.

Shellfish Relay for Natural Cleansing – Oysters, clams, or mussels transplanted from a polluted to a clean environment will cleanse themselves of the polluting bacteria or viruses. To protect public health and to make good use of a valuable natural resource, approval and authorization from MDE is required for this activity. Relay can only occur when water temperatures are above 50° F and from April – August. Approval is good only for the one relay activity and the time it takes to complete the relay activity requested. Turnaround time for this authorization is 7 days.

MDE reviews and adjusts these turnaround times annually to give permit applicants current information regarding the processing time.

Please note the following important points about these standard times:

1) These standards refer to the time between MDE's receipt of a complete permit application and MDE's issuance or denial of the permit, excluding delays caused by factors beyond MDE's control. Many applications are incomplete when they first arrive at MDE. The appropriate MDE permit writer can provide guidance on how to ensure that an application is complete when submitted.

2) In most permitting programs, each application has unique characteristics that influence its processing time. For each program listed, the standard time represents the time in which 90% of applications can be processed. Many applications will require less time; a few will require more time due to unusual circumstances.

Program Name	2017 Standard Application Processing Time
Air and Radiation Management Administration	
General Permit to Construct	30 days
Air Quality Permit to Construct	3 months - without expanded public review
	4 months – synthetic minor permits without expanded public review
	6 months - with expanded public review but limited public interest
	11 months - with expanded public review and extensive public interest
New Source Review Approval	12 months
Prevention of Significant [air quality] Deterioration	12 months
Air Quality State Permit to Operate	3 months
Part 70 (Title V) Permit to Operate	18 months for new permits
	12 months for renewals
Asbestos Contractor License	60 days
Asbestos Training Provider Approval	3 months
Incinerator Operator Certification	30 days

Program Name	2017 Standard Application Processing Time
Incinerator Training Course Approval	60 days
Fleet Inspection Station License	30 days
Certified Emissions Repair Facility Certification	30 days
Master Certified Emissions Technician Certificate	30 days
Radiation Machine Facility Registration	60 days for dental and veterinary machines
	4 months for all other machines
Certification of Machines Emitting Radiation	6 months
Radioactive Materials License	7 months
	45 days for amendments and terminations
Private Inspector License For Inspecting X-Ray Machines	60 days
Reciprocal Recognition of Out-of-State Radioactive Material Licenses	21 days
Land Management Administration	
Refuse Disposal Permit	7 months for transfer stations
	9 months for processing facilities
	9 months for processing facilities & transfer stations
	12 months for incinerators
	12 months for land-clearing debris landfills
	24 months for industrial landfills
	36 months for rubble landfills
	36 months for municipal landfills
Groundwater Discharge Permit for Rubble Landfill	18 months
Sewage Sludge Utilization Permit	120 days – research project
	3 months – transportation
	5 months – utilization or disposal at a sanitary landfill, energy generation, or incineration
	6 months – marketing
	10 months – land application
	23 months – treatment, composting, distribution facility, or storage
	36 months – sewage sludge landfill
	24 months – innovative projects
General Discharge Permit for Animal Feeding Operations	160 days for new construction
	36 months for renewal
Natural Wood Waste Recycling Facility Permit	9 months
Natural Wood Waste Recycling Facility General Permit	60 days
Individual Composting Facility Permit	220 days
General Composting Facility Permit	120 days
Scrap Tire Hauler	60 days
Scrap Tire Collection Facilities (General and Secondary)	60 days
Scrap Tire Solid Waste Acceptance Facility	7 months
Scrap Tire TDF/Substitute Fuel Facility	7 months
Scrap Tire Primary Collection Facility	9 months
Scrap Tire Recyclers	9 months
Oil Operations Permit	180 days
Oil Operations Permit for Oil-Contaminated Soils	180 days
Oil Transfer License	30 days
General Permits for Oil Control Program Wastewater Discharge Permit	30 days
Surface Water Discharge Permit for Oil Terminals	180 days

Program Name	2017 Standard Application Processing Time
Ground Water Discharge Permit for Oil Terminals	180 days
Underground Storage Tank (UST) Technician, Remover, and Inspector Certifications	30 days
Controlled Hazardous Substances Facility Permit	26 months
Hazardous Waste; EPA Identification Number	30 days
Controlled Hazardous Substances Hauler and Vehicle Certifications	60 days
Special Medical Waste (SMW) Hauler and Vehicle Certifications	60 days
Coal Mining Permit	12 months
Surface Coal Mining Blaster Certification	immediately on passing exam
Coal Mining Operator License	30 days
Non-Coal Mining Permit	4 months
Non-Coal Mining License	20 days
Oil and Gas Exploration and Production	5 months
Lead Paint Accreditations	60 days
Lead Paint Training Course Approvals	60 days
Lead Paint Instructor Approvals	60 days
Voluntary Cleanup Program	45 days to determine if application is accepted
	75 days to review action plan
Water Management Administration	
General Discharge Permit Registrations (excluding Construction Activities and Animal Feeding Operations)	100 days for all general permits
Individual Permit for Wastewater Discharges	12 months for new minor surface facilities
	18 months for new surface major facilities
	24 months for renewal surface discharge facilities
	18 months for new groundwater discharge facilities
	34 months for renewal groundwater discharge facilities
Toxic Materials Permit	45 days
Water and Sewerage Construction Permit	3 months
Water Appropriation and Use Permit	90 days for under 10,000 gallons per day
	18 months for over 10,000 gallons per day
Well Construction Permit	30 days
Drinking Water Laboratory Certification	4 months
Nontidal Wetlands and Waterway Construction (Nontidal Wetlands and Waterways Permits)	8 months for minor projects
	12 months for major projects
	90 days for stream restoration projects when no public hearing is requested
Tidal Wetland Licenses and Permits	90 days for minor projects
	8 months for major projects when no public hearing is requested
	11 months for major projects when a public hearing is requested
Erosion/Sediment Control and Stormwater Management Plan Approvals	6 months
Erosion and Sediment Control - Responsible Personnel Certification - Online	1 day
Erosion and Sediment Control - Responsible Personnel Training Program Approval	4 weeks
General Permit for Stormwater Associated with Construction Activity	45 days
Individual Permit for Stormwater Associated with Construction Activity	6 months
Municipal Separate Storm Sewer Permit	18 months
Dam Safety Permit	6 months

Program Name	2017 Standard Application Processing Time
Waterworks and Waste Systems Operator Certification	30 days for all licenses
Well Driller License	6 months for new licenses
	30 days for renewals
Science Services Administration	
Wet Storage of Shellfish	30 days
Shellfish Relay for Natural Cleansing	7 days

[16-26-25]

INFORMATIONAL PUBLIC MEETING ANNOUNCEMENT

Maryland's Draft 2016 Integrated Report of Surface Water Quality

The Federal Clean Water Act requires that States assess the quality of their waters every two years and publish a list of waters not meeting the water quality standards set for them. This list of impaired waters is included in the State's biennial Integrated Report (IR) of Surface Water Quality. Waters identified in Category 5 of the IR are impaired and may require the development of Total Maximum Daily Loads (TMDLs). The Maryland Department of the Environment (MDE) is announcing the availability of the Draft 2016 IR for public review and comment. The public review period will run from **December 23 to January 23, 2017**. The Draft IR is being posted on MDE's website at http://www.mde.state.md.us/programs/Water/TMDL/Integrated303dReports/Pages/2016IR.aspx. Hard copies of the Draft IR may be requested by calling Ms. Rebecca Lang at (410) 537-3947. *Please note that the Department charges a fee to cover printing and shipping costs.*

The Department is hosting an informational public meeting and conference call in Baltimore at 6pm on January 9, 2017. Any hearing impaired person may request an interpreter to be present at the meeting by giving five (5) working days notice to Rebecca Lang at rebecca.lang@maryland.gov or by calling (410) 537- 3947. Anyone wanting to participate in this meeting via conference call should also contact Rebecca Lang, in advance, for instructions. Given enough interest, the Department may schedule additional meetings. Comments or questions may be directed in writing to Mr. Matthew Stover, MDE, Science Services Administration, 1800 Washington Blvd., Baltimore, Maryland 21230, emailed to matthew.stover@maryland.gov, or faxed to the attention of Mr. Matthew Stover at 410-537-3873 on or before **January 23, 2017**. After addressing all comments received during the public review period, a final IR will be prepared and submitted to the U.S. Environmental Protection Agency for approval.

Public Meeting Announcement

Date: January 9, 2017
Start Time: 6:00 p.m.
Location: MDE Headquarters
Lobby Conference Rooms (to the left after entering the front door)
1800 Washington Blvd.
Baltimore MD, 21230
Parking: Red Lot, Front (south) of building

[16-26-33]

SUSQUEHANNA RIVER BASIN COMMISSION

Projects Approved for Consumptive Uses of Water

AGENCY: Susquehanna River Basin Commission.

ACTION: Notice.

SUMMARY: This notice lists the projects approved by rule by the Susquehanna River Basin Commission during the period set forth in "DATES."

DATES: October 1-31, 2016.

ADDRESSES: Susquehanna River Basin Commission, 4423 North Front Street, Harrisburg, PA 17110-1788.

FOR FURTHER INFORMATION CONTACT: Jason E. Oyler, General Counsel, telephone: (717) 238-0423, ext. 1312; fax: (717) 238-2436; e-mail: joyler@srbc.net. Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: This notice lists the projects, described below, receiving approval for the consumptive use of water pursuant to the Commission's approval by rule process set forth in 18 CFR §806.22(f) for the time period specified above:

Approvals By Rule Issued Under 18 CFR 806.22(f):

Talisman Energy USA, Inc., Pad ID: 02 113 Reinfried C, ABR-201109004.R1, Warren Township, Tioga County, Pa.; Consumptive Use of Up to 6.0000 mgd; Approval Date: October 5, 2016.

Chesapeake Appalachia, LLC, Pad ID: Circle Z BRA, ABR-201203031.R1, Wilmot Township, Bradford County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 5, 2016.

Chesapeake Appalachia, LLC, Pad ID: Floydie, ABR-201203019.R1, Tuscarora Township, Bradford County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 5, 2016.

Chesapeake Appalachia, LLC, Pad ID: Hattie BRA, ABR-201203030.R1, Wilmot Township, Bradford County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 5, 2016.

Chesapeake Appalachia, LLC, Pad ID: Maggie, ABR-201203020.R1, Tuscarora Township, Bradford County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 5, 2016.

Chesapeake Appalachia, LLC, Pad ID: R&N, ABR-201203014.R1, Cherry Township, Sullivan County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 5, 2016.

EOG Resources, Inc., Pad ID: WOLFE Pad, ABR-201110033.R1, Smithfield Township, Bradford County, Pa.; Consumptive Use of Up to 4.9990 mgd; Approval Date: October 6, 2016.

EOG Resources, Inc., Pad ID: WALLACE Pad, ABR-201110032.R1, Smithfield Township, Bradford County, Pa.; Consumptive Use of Up to 4.9990 mgd; Approval Date: October 6, 2016.

EOG Resources, Inc., Pad ID: PRUYNE 1H Pad, ABR-201110034.R1, Smithfield Township, Bradford County, Pa.; Consumptive Use of Up to 4.9990 mgd; Approval Date: October 6, 2016.

SWN Production Company, LLC, Pad ID: CSB, ABR-201108013.R1, Cherry Township, Sullivan County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 11, 2016.

Cabot Oil & Gas Corporation, Pad ID: WilliamsD P1, ABR-201110018.R1, Brooklyn Township, Susquehanna County, Pa.; Consumptive Use of Up to 3.5750 mgd; Approval Date: October 11, 2016.

SWN Production Company, LLC, Pad ID: CHILSON-JENNINGS, ABR-201201012.R1, Herrick Township, Bradford County, Pa.; Consumptive Use of Up to 4.9990 mgd; Approval Date: October 13, 2016.

Chesapeake Appalachia, LLC, Pad ID: Manning, ABR-201204009.R1, Cherry Township, Sullivan County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 17, 2016.

Chesapeake Appalachia, LLC, Pad ID: Freed, ABR-201204014.R1, Albany Township, Bradford County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 17, 2016.

Chesapeake Appalachia, LLC, Pad ID: Reilly, ABR-201204015.R1, Colley Township, Sullivan County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 17, 2016.

EOG Resources, Inc., Pad ID: ASHBY Pad, ABR-201110031.R1, Athens and Smithfield Townships, Bradford County, Pa.; Consumptive Use of Up to 4.9990 mgd; Approval Date: October 17, 2016.

SWN Production Company, LLC, Pad ID: Carty-Wisemen Well Pad, ABR-201109006.R1, Liberty Township, Susquehanna County, Pa.; Consumptive Use of Up to 4.0000 mgd; Approval Date: October 17, 2016.

SWN Production Company, LLC, Pad ID: Kass North Well Pad, ABR-201109007.R1, Liberty Township, Susquehanna County, Pa.; Consumptive Use of Up to 4.0000 mgd; Approval Date: October 17, 2016.

SWN Production Company, LLC, Pad ID: Robinson Well Pad, ABR-201109009.R1, Liberty Township, Susquehanna County, Pa.; Consumptive Use of Up to 4.0000 mgd; Approval Date: October 17, 2016.

SWN Production Company, LLC, Pad ID: HDK Pad, ABR-201112001.R1, Franklin Township, Susquehanna County, Pa.; Consumptive Use of Up to 4.0000 mgd; Approval Date: October 17, 2016.

Chief Oil & Gas LLC, Pad ID: Leh Drilling Pad #1, ABR-201204002.R1, Burlington Township, Bradford County, Pa.; Consumptive Use of Up to 2.0000 mgd; Approval Date: October 19, 2016.

Talisman Energy USA, Inc., Pad ID: 03 078 Bellows L, ABR-201610001, Columbia Township, Bradford County, Pa.; Consumptive Use of Up to 6.0000 mgd; Approval Date: October 21, 2016.

SWN Production Company, LLC, Pad ID: HOWLAND-LENT, ABR-201112032.R1, Herrick Township, Bradford County, Pa.; Consumptive Use of Up to 4.9990 mgd; Approval Date: October 21, 2016.

Chesapeake Appalachia, LLC, Pad ID: Rainbow BRA, ABR-201203033.R1, Terry Township, Bradford County, Pa.; Consumptive Use of Up to 7.5000 mgd; Approval Date: October 24, 2016.

Inflection Energy (PA), LLC, Pad ID: Ultimate Warrior, ABR-201111036.R1, Upper Fairfield Township, Lycoming County, Pa.; Consumptive Use of Up to 4.0000 mgd; Approval Date: October 27, 2016.

Range Resources – Appalachia, LLC, Pad ID: Bobst Unit #34H-#37H, ABR-201111004.R1, Cogan House Township, Lycoming County, Pa.; Consumptive Use of Up to 1.0000 mgd; Approval Date: October 31, 2016.

Range Resources – Appalachia, LLC, Pad ID: Sechrist, Mark - #1H-#3H, ABR-201111005.R1, Anthony Township, Lycoming County, Pa.; Consumptive Use of Up to 1.0000 mgd; Approval Date: October 31, 2016.

Range Resources – Appalachia, LLC, Pad ID: Red Bend B Unit - #1H-#8H, ABR-201111006.R1, Cogan House Township, Lycoming County, Pa.; Consumptive Use of Up to 1.0000 mgd; Approval Date: October 31, 2016.

Range Resources – Appalachia, LLC, Pad ID: Red Bend C Unit - #1H-#5H, ABR-201111007.R1, Cogan House Township, Lycoming County, Pa.; Consumptive Use of Up to 1.0000 mgd; Approval Date: October 31, 2016.

AUTHORITY: Pub. L. 91-575, 84 Stat. 1509 et seq., 18 CFR Parts 806, 807, and 808.

Dated: November 28, 2016.

STEPHANIE L. RICHARDSON
Secretary to the Commission

[16-26-07]

SUSQUEHANNA RIVER BASIN COMMISSION

Projects Rescinded for Consumptive Uses of Water

AGENCY: Susquehanna River Basin Commission.

ACTION: Notice.

SUMMARY: This notice lists the approved by rule projects rescinded by the Susquehanna River Basin Commission during the period set forth in "DATES."

DATES: October 1-31, 2016.

ADDRESSES: Susquehanna River Basin Commission, 4423 North Front Street, Harrisburg, PA 17110-1788.

FOR FURTHER INFORMATION CONTACT: Jason E. Oyler, General Counsel, telephone: (717) 238-0423, ext. 1312; fax: (717) 238-2436; e-mail: joyler@srbc.net. Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: This notice lists the projects, described below, being rescinded for the consumptive use of water pursuant to the Commission's approval by rule process set forth in 18 CFR §806.22(e) and §806.22(f) for the time period specified above:

Rescinded ABRs Issued

Chesapeake Appalachia, LLC, Pad ID: A&M, ABR-201501005, Wilmot Township, Bradford County, Pa.; Rescind Date: October 27, 2016.

Chesapeake Appalachia, LLC, Pad ID: Dingo, ABR-201401008, Cherry Township, Sullivan County, Pa.; Rescind Date: October 27, 2016.

Chesapeake Appalachia, LLC, Pad ID: Kintner, ABR-201309016, Wilmot Township, Bradford County, Pa.; Rescind Date: October 27, 2016.

Chesapeake Appalachia, LLC, Pad ID: Three D Acres, ABR-201301009, Monroe Township, Bradford County, Pa.; Rescind Date: October 27, 2016.

Chesapeake Appalachia, LLC, Pad ID: Windswept, ABR-201407002, Auburn Township, Susquehanna County, Pa.; Rescind Date: October 27, 2016.

Chesapeake Appalachia, LLC, Pad ID: Packard, ABR-2011050122.R1, Sheshequin Township, Bradford County, Pa.; Rescind Date: October 31, 2016.

AUTHORITY: Pub. L. 91-575, 84 Stat. 1509 et seq., 18 CFR Parts 806, 807, and 808.

Dated: November 28, 2016.

STEPHANIE L. RICHARDSON
Secretary to the Commission

[16-26-08]

WATER MANAGEMENT ADMINISTRATION

Notice of Tentative Determination to Issue a General Permit for Discharges from State and Federal Small Municipal Separate Storm Sewer Systems
General Discharge Permit No. 13-SF-5501,
General NPDES No. MDR055501

The Maryland Department of the Environment, Water Management Administration (MDE\WMA) has reached a tentative determination to issue a National Pollutant Discharge Elimination System (NPDES) General Permit for Discharges from State and Federal Small Municipal Separate Storm Sewer Systems (General Discharge Permit No. 13-SF-5501, General NPDES No. MDR055501). MDE has drafted a general permit designed to comply with United States Environmental Protection Agency's (EPA) regulations and to control stormwater pollutant discharges from small municipal separate storm sewer systems. The permit is issued for five years.

Under the conditions of this permit, State and federal properties eligible for coverage will be required to implement the following six minimum measures: personnel education and outreach; public participation and involvement; illicit discharge detection and elimination; construction site stormwater runoff control; post-construction stormwater management; and pollution prevention/good housekeeping. The permit also outlines new requirements for impervious area restoration for twenty percent of existing developed lands that have little or no stormwater management. Restoration planning strategies and implementation schedules required under the conditions of this permit term are consistent with addressing the water quality goals of the Chesapeake Bay TMDL by 2025. Implementation of these permit conditions will establish improved stormwater controls to reduce the discharge of pollutants, protect water quality, and satisfy the water quality requirements of federal regulations under the Clean Water Act. Penalties for failure to comply with the terms of this permit are provided.

For more information on stormwater management in Maryland or to review the permit and fact sheet, go to: http://mde.maryland.gov/SWM or contact Mr. Raymond Bahr, Raymond.Bahr@Maryland.gov, or by phone at 410-537-3545 or 1-800-633-6101 to make an appointment during the hours of 8:00 a.m. to 5:00 p.m. Copies of the document may be procured at a cost of 36¢ per page.

MDE will hold a public hearing concerning this tentative determination from 1:30 PM to 3:30 PM on February 6, 2017 at Maryland Department of the Environment, Aqua/Terra/Aeris conference rooms, 1800 Washington Blvd., Baltimore, Maryland, 21230. Any hearing impaired person may request an interpreter at the hearing by contacting the Office of Fair Practices at 410-537-3964 at least ten working days prior to the scheduled hearing date. TTY users should contact the Maryland Relay Service at 1-800-201-7165.

Written comments should be directed to Mr. Raymond Bahr, Maryland Department of the Environment, Water Management Administration, Sediment, Stormwater, and Dam Safety Program, 1800 Washington Blvd., STE 440, Baltimore, Maryland 21230-1708. Written comments concerning this tentative determination will be accepted through March 30, 2017. This comment period already incorporates the additional 60 day extension period provided in Environment Article §1-606(d)(2)(ii).

[16-26-18]

WATER MANAGEMENT ADMINISTRATION

Notice of Tentative Determination and Public Hearing — General Permit for Discharges from Small Municipal Separate Storm Sewer Systems
General Discharge Permit No. 13-IM-5500,
General NPDES No. MDR055500

The Maryland Department of the Environment, Water Management Administration (MDE\WMA) has reached a tentative determination to issue a National Pollutant Discharge Elimination System (NPDES) General Permit for Discharges from Small Municipal Separate Storm Sewer Systems (General Discharge Permit No. 13-IM-5500, General NPDES No. MDR055500). MDE has drafted a general permit designed to comply with United States Environmental Protection Agency's (EPA) regulations and to control stormwater pollutant discharges from small municipal separate storm sewer systems. The permit is issued for five years.

Under the conditions of this permit, municipalities designated for coverage will be required to implement the following six minimum measures: public education and outreach; public participation and involvement; illicit discharge detection and elimination; construction site stormwater runoff control; post-construction stormwater management; and pollution prevention/good housekeeping. The permit also outlines new requirements for impervious area restoration for twenty percent of existing developed lands that have little or no stormwater management. Restoration planning strategies and implementation schedules required under the conditions of this permit term are consistent with addressing the water quality goals of the Chesapeake Bay TMDL by 2025. Implementation of these permit conditions will establish improved stormwater controls to reduce the discharge of pollutants, protect water quality, and satisfy the water quality requirements of federal regulations under the Clean Water

Act. Penalties for failure to comply with the terms of this permit are provided.

For more information on stormwater management in Maryland or to review the permit and fact sheet, go to: http://mde.maryland.gov/SWM or contact Mr. Raymond Bahr, Raymond.Bahr@Maryland.gov, or by phone at 410-537-3545 or 1-800-633-6101 to make an appointment during the hours of 8:00 a.m. to 5:00 p.m. Copies of the document may be procured at a cost of 36¢ per page.

MDE will hold a public hearing concerning this tentative determination from 10:00 AM to 12:00 PM on February 6, 2017 at Maryland Department of the Environment, Aqua/Terra/Aeris conference rooms, 1800 Washington Blvd., Baltimore, Maryland, 21230. Any hearing impaired person may request an interpreter at the hearing by contacting the Office of Fair Practices at 410-537-3964 at least ten working days prior to the scheduled hearing date. TTY users should contact the Maryland Relay Service at 1-800-201-7165.

Written comments should be directed to Mr. Raymond Bahr, Maryland Department of the Environment, Water Management Administration, Sediment, Stormwater, and Dam Safety Program, 1800 Washington Blvd., STE 440, Baltimore, Maryland 21230-1708. Written comments concerning this tentative determination will be accepted through March 30, 2017. This comment period already incorporates the additional 60 day extension period provided in Environment Article §1-606(d)(2)(ii).

[16-26-17]

DEPARTMENT OF TRANSPORTATION

OFFICE OF MINORITY BUSINESS ENTERPRISE (OMBE)

Subject: Announcement of Calendar Year 2017 Limitation on the Personal Net Worth of a Socially and Economically Disadvantaged Individual as it relates to Certification of a Minority Business Enterprise (MBE)
Add'l. Info.: The Maryland Department of Transportation Office of Minority Business Enterprise (OMBE) gives notice that the limitation on the personal net worth of a disadvantaged owner whose ownership interest in a firm is relied upon for certification in the State's Minority Business Enterprise (MBE) program, will be $1,692,682 (one million six hundred ninety- two thousand six hundred eighty-two dollars) effective January 1, 2017. The limitation described above will apply to all MBE certification decisions rendered between January 1, 2017 and December 31, 2017. This action is taken in accordance with the Annotated Code of Maryland State Finance and Procurement Article § 14-301(i)(3).
Contact: Sabrina Bass (410) 865-1240

[16-26-13]

General Notices

Notice of ADA Compliance

The State of Maryland is committed to ensuring that individuals with disabilities are able to fully participate in public meetings. Anyone planning to attend a meeting announced below who wishes to receive auxiliary aids, services, or accommodations is invited to contact the agency representative at least 48 hours in advance, at the telephone number listed in the notice or through Maryland Relay.

ATHLETIC COMMISSION

Subject: Public Meeting
Date and Time: January 25, 2017, 2 — 5 p.m.
Place: 500 N. Calvert St., 3rd Fl. Board Rm., Baltimore, MD
Contact: Patrick Pannella (410) 230-6223

[16-26-11]

ADVISORY COUNCIL ON CEMETERY OPERATIONS

Subject: Public Meeting
Date and Time: January 26, 2017, 10 a.m. — 1 p.m.
Place: Dept. of Labor, Licensing, and Regulation, 500 N. Calvert St., 3rd Fl. Conf. Rm., Baltimore, MD
Contact: Deborah Rappazzo (410) 230-6229

[16-26-16]

COMPTROLLER OF THE TREASURY/ADMINISTRATION AND FINANCE

Subject: Reduction of Bond Authorization Announcement
Add'l. Info: Pursuant to State Finance and Procurement Article, §8-128, Annotated Code of Maryland, which provides that if within, 2 years after the date of an authorization of State debt, no part of the project or program for which the enabling act authorized the State debt is under contract and the Board of Public Works has not committed money for any part of the project or program, the authorization terminates unless:

(1) The enabling act provides otherwise; or

(2) In an emergency, the Board unanimously grants a temporary exception for a period of 1 year.

Therefore, with Board of Public Works approval of item #4, dated December 7, 2016, we submit for publication the following cancellation of bond authorizations in accordance with the above-referenced articles:

Ebenezer Community Life Center: Ch. 46, Acts of 2006, amended by Ch. 396, Acts of 2011, and Ch.495, Acts of 2015; $55,999; authorized the funds for the planning, design, construction, renovation, reconstruction, and capital equipping of the Community Life Center, located in Lanham.

Germantown Boys and Girls Gymnasium: Ch. 488, Acts of 2007; $46,374.57; authorized the funds for the planning, design, construction, repair, and capital equipping of a gymnasium at the Germantown branch of the Boys and Girls Clubs of Greater Washington, located in Germantown.

St. Agnes Healthcare: Ch. 488, Acts of 2007; $57,446.51; authorized the funds for the planning, design, renovation, expansion, repair, construction, and capital equipping of the birthing center and neonatal intensive care unit at St. Agnes Hospital, located in Baltimore City.

Milford Mill Academy Sign: Ch. 483, Acts of 2010; $9,836.32; authorized the funds for the Milford Mill Academy, located in Baltimore County.

Supported Living Facility: Ch. 444, Acts of 2012, amended by Ch. 463, Acts of 2014; $34,393.62; authorized the funds for the planning, design, construction, repair and renovation, and capital equipping, including replacing the HVAC system, of the Supported Living Facility, located in Columbia.

William Paca House: Ch. 424, Acts of 2013; $25; authorized the funds for the design, construction, repair, renovation, reconstruction, and capital equipping of the William Paca House.

Re Rentuma
Fiscal Specialist
Administration and Finance
Contact: Re Rentuma (410) 260-7909

[16-26-15]

BOARD OF DIETETIC PRACTICE

Subject: Public Meeting
Date and Time: January 19, 2017, 10 a.m. — 12 p.m.
Place: 4201 Patterson Ave., Rm. 106, Baltimore, MD
Contact: Lenelle Cooper (410) 764-4733

[16-26-05]

DEPARTMENT OF THE ENVIRONMENT

Subject: Public Meeting
Date and Time: January 9, 2017, 6 p.m.
Place: MDE Headquarters, 1800 Washington Blvd., Lobby Conf. Rms., Baltimore, MD
Add'l. Info: Public Meeting on Maryland's Draft 2016 Integrated Report of Surface Water Quality
Contact: Matthew M. Stover (410) 537-3611

[16-26-32]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE/OFFICE OF HEALTH SERVICES

Subject: Public Notice for Community First Choice Daily Rate Initiative — Comment Analysis and Public Notice Restatement
Add'l. Info: Following stakeholder input, the Department is proposing to change the Community First Choice reimbursement methodology to better align services delivered with payment. The proposal includes a new comprehensive daily rate to better address full services delivered to participants.

The projected fiscal impact is $0. The Department currently reimburses a fee-for-service rate for Community First Choice related services. The proposed change adds a daily rate to better address the full needs of the participants who need more than 12 hours of personal assistance per day. The updated proposed effective date is February 1, 2017.

This information was originally posted on the Department's website and distributed to stakeholders on November 9, 2016, and posted in Maryland Register on November 28, 2016.

Below are the comments received and the Department's response.

Agencies were concerned that the rate is too low for agencies to provide 24-hour support while complying with labor laws for overtime payments. Providers fear it would create a cap on hours because agencies would be unable to provide the needed services in order to avoid overtime compensation or violating labor laws. This amounts to a denial of services without appeal rights. However, the Department

currently does not have anyone who is approved for 24-hour personal assistance. The highest level is 16 hours per day and only two participants are approved for 16 hours per day. The daily rate does not require 24-hour in-home support. Agencies have the flexibility to use multiple workers per day and, therefore, would have no need to pay overtime for an individual provider or violate labor laws. The Department reminded providers that sleeping hours may be unpaid under labor rules in many circumstances. Other comments indicated that some agencies are willing to use this structure. As in former per diem models, the agency would be responsible for providing for the participant's needs within the rate. The former rate in the legacy Medical Assistance Personal Care program was $52.53 per day for up to 24 hours of support, and there was an adequate supply of providers willing to provide the service with minimal quality issues. Lastly, the daily rate is set to match the cost to Medicaid for a day of nursing facility care to allow waiver participants, who are subject to waiver cost neutrality, to have equal access to the service. In nursing facilities, the direct care hours are well below 12 per day. The Department will continue to monitor and, if necessary, adjust the daily rate if these concerns come to fruition.

There were also comments regarding quality. Stakeholders noted that the old daily rate method tended to skew hours down and allowed providers to receive the rate while the participant may, or may not, be receiving the additional hours of service.

This was a concern when the Department accepted paper claims; however, the Department now uses ISAS to record and pay out claims. ISAS claims show in real time when a provider is clocked in. Supports planners are required to review this monthly. Nurse monitoring includes participant assessments and quality oversight. Reportable events and case notes in the web-based tracking system allow providers to share information instantly and offer transparency into the process and quality of care. This quality structure did not exist in the old programs and offers a new way to monitor service provision and identify and correct issues before they become a crisis or pattern. A requirement that plans with a daily rate be evaluated every 3 months will increase the scrutiny on this service and offer an additional layer of State oversight into the services and any quality concerns during quarterly utilization and service review.

There were additional concerns that individuals affected by the daily rate were not involved in the stakeholder process. The Department did ensure that individuals impacted were involved in the process. Three individuals, who are approved for more than 12 hours and would be affected by the daily rate implementation, were represented in the Council discussion; however, the individuals did not self-disclose, and the Department did not identify them to the council or general public in order to maintain confidentiality. Additionally, one member who would be directly impacted stated that, if available, he would use the daily rate.

Stakeholders comment that there has not been enough information available for public comment or sufficient time to consider the proposal. The Department introduced the idea to the Council at the September 28th meeting. Additional information was provided at the November 4th meeting, as requested. Draft language was sent to the council for review on November 9th. Notice was posted in the Maryland Register on November 28th. The topic was discussed again on December 5th. The Department has been discussing the changes with the council for over 2 months, offered draft language for review nearly 30 days prior to the meeting, and provided data analysis of who would be impacted as requested.

Providers proposed making the daily rate an option, and not required. Making this optional creates an inequity between waiver participants and individuals who meet community financial eligibility standards. Currently, waiver participants are subject to cost neutrality caps. If optional, only community eligible individuals would have the option to receive hourly payments over 12 hours per day.

Stakeholders also commented that the daily rate should be held until self-direction is an option so that individuals can set their own rates for their workers. The Department's existing agency model requires that participants have a voice in their services and a role in directing their workers and managing their services. The current model allows a participant to set their schedule and work with an agency in similar ways to a self-directed model. Delaying implementation is unnecessary as participants currently have flexibility with the agency model.

Stakeholders also requested the Department add language regarding items that substitute for human assistance to clarify that the item does not need to reduce the number of hours the participant receives. The Department feels that the clarification in the state plan is unnecessary as the policy for items that substitute for human assistance is adequate to address this concern. Training materials, regulations, and practice reflect this policy related to pre-authorizing items that substitute for human assistance.

Stakeholders had comments outside the proposed changes, which the Department addressed, and the Department continues to engage stakeholders.

Written comments may be sent to Lorraine Nawara, Office of Health Services, DHMH 201 W. Preston St., Baltimore, MD 21201, or emailed to lorraine.nawara@maryland.gov.

Contact: Nina McHugh (410) 767-5003

[16-26-26]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE/OFFICE OF HEALTH SERVICES

Subject: Public Notice for Opioid Treatment Program Reimbursement Rebundling Initiative—Comment Analysis and Public Notice Restatement

Add'l. Info: Following stakeholder input, the Department is proposing to change the methadone reimbursement methodology to better align services delivered with payment. The proposal includes a new comprehensive rate specifically for medication assisted treatment services and a separate reimbursement for Level 1 counseling services when delivered by appropriately licensed professionals. Opioid Treatment Programs (OTPs) may separately bill for services including an induction service of the selected medication (methadone or buprenorphine), periodic medication management visits, and guest dosing services.

The projected fiscal impact is $0. The Department currently reimburses a bundled rate for Opioid Treatment Program methadone and buprenorphine related services. The proposed change isolates Level 1 counseling services, currently required and included in the bundled rate, to be reimbursed separately. The proposed effective date is March 1, 2017.

The majority of comments received by the Department during the development of the rebundling initiative were supportive of the overall structure and goals of the proposal but focused on issues concerning the rate for the bundled methadone and buprenorphine services. Both the rate focused comments and outside provider feedback suggests that some programs offer little to no counseling despite the "Federal opioid treatment standards" 42 CFR § 8.12 requirement that adequate substance abuse counseling be provided to each patient as clinically necessary and clinical evidence that counseling is an

important aspect of medication assisted treatment. Due to enhanced understandings of the laboratory services included in the bundle and information on costs provided by providers, the bundled methadone treatment service rate was increased through the stakeholder process from an original proposal of $42 per week to $63 per week. Likewise the bundled buprenorphine treatment service rate was increased through the stakeholder process from an original proposal of $35 per week to $56 per week. Despite an increase in bundled rate, the State determined that the changes maintain budget neutrality. Based on information from stakeholders, this rebundling will likely reduce the number of other services billed.

Some providers have informed the Department that they do not have adequate space in their buildings for group counseling and therefore it will be difficult for them to remain financially viable. All levels of counseling, under the current reimbursement structure, are included in the bundled rate. Providers' comments suggest that some patients are missing out on a valuable resource from their peers and counselors. A separate counseling rate will hopefully lead the way for more group services or will at least allow the State to track whether such services are delivered in the future.

Some OTPs were concerned that most of their patients are in the maintenance phase of recovery and therefore will not require a lot of counseling. In the current process when an individual is in the recovery phase, providers cannot bill Medicaid the weekly bundled rate unless the individual comes into the office for a face-to-face visit in that week. The rebundling proposal aligns the reimbursement process with the real-life slope of recovery so that individuals in the maintenance phase can be seen by the provider once a month and the provider would still receive the weekly bundle for as long as the patient is in treatment. New York implemented a similar rebundling initiative and found it created higher overall revenue for OTPs, leading to new centers opening each year of its implementation. As such, Maryland assumes similar results in Maryland, and the initiative will not impact access to care.

Finally, some providers have suggested that the Department, by virtue of rebundling services, is suggesting that providers should disenroll patients who refuse counseling, or that providers will need to "force" individuals into counseling. The Department reminded providers that counseling is already a federally mandated requirement under the current OTP service. A skilled clinician should help the patient understand the benefit to meeting on an individual or group level once a week during the earlier stages of the recovery process. However, the Department is not suggesting that patients be forced into counseling or discharged if they refuse counseling.

To view the full initiative, a more detailed summary of changes, and a complete list of comments received and Departmental responses, please see the documents posted on the Behavioral Health Integration webpage:
http://dhmh.maryland.gov/bhd/Pages/Integration-Efforts.aspx.

Written comments may be sent to Elaine Hall, Office of Health Services, DHMH 201 W. Preston St., Rm. 213a, Baltimore, MD 21201, or emailed to dhmh.mabehavioralhealth@maryland.gov.
Contact: Elaine Hall, (410) 767-1998

[16-26-27]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE/OFFICE OF HEALTH SERVICES

Subject: Public Notice Waiver for Children with Autism Spectrum Disorder Amendment
Add'l. Info: Home and Community-Based Waiver for Children with Autism Spectrum Disorder Amendment #1:

The Department of Health and Mental Hygiene (DHMH) is proposing an amendment to the Home and Community-Based Waiver for Children with Autism Spectrum Disorder application. The amendments are based on new federal rules and requirements from the Center for Medicare and Medicaid Services (CMS). Requests to make changes to the wavier program are made by submitting a Waiver Amendment to CMS.

Proposed Updates:

(1) Update to Appendix I.2.a — Include specific information gathered in the Autism Waiver Rate Methodology Study conducted to ensure that Maryland rates are both economical and efficient.
Following is the link to the Rate Methodology Study:
https://dhmh.maryland.gov/waiverprograms/Pages/Home.aspx

(2) Update to Appendix C.5 — Explain how residential and nonresidential settings in this waiver comply with federal Home and Community-Based Settings requirements at 42 CFR 441.301(c)(4)—(5) and associated CMS guidance. Following is the link to the full Transition Plan:
https://mmcp.dhmh.maryland.gov/waiverprograms/pages/Community-Settings- Final-Rule.aspx

(3) Update to Appendix G.2.c — Specify the State agency responsible for detecting the unauthorized use of seclusion and how oversight is conducted and its frequency.

The OSA, MSDE, is responsible for detecting the unauthorized use of seclusion. Providers must report any incidents of seclusion through the reportable event process. These incidents must be reviewed and may be investigated by MSDE, followed by a Corrective Action Plan and technical assistance, as needed.

Additionally, the OSA, MSDE, and the SMA, OHS, conduct annual audits. During the annual audits, Autism Waiver documentation is reviewed to identify the unauthorized use of seclusion. As a result of the monitoring, MSDE may initiate an investigation or request a Corrective Action Plan and OHS may request sanctions or repayment of Medicaid funds from providers when appropriate.

Next Steps:

- Public comment period December 23, 2016 through January 23, 2017
- State review of comments and consideration for revisions to amendment — February 2017
- Waiver Amendment Submission to CMS — February 2017
- Respond to CMS Questions — March 2017
- Projected CMS Approval — April 2017
- Projected effective Date — May 2017

Contact: Rebecca Oliver (410) 767-4902

[16-26-28]

Agency/Department Sort Name: Health

DEPARTMENT OF HEALTH AND MENTAL HYGIENE/OFFICE OF HEALTH SERVICES

Subject: Public Notice for January 1, 2017, Fee Schedule
Add'l. Info: Maryland Medical Assistance (Medicaid) updated its professional fee schedule for dates of service beginning January 1, 2017. Medicaid will reduce rates that previously exceeded 100 percent of Medicare to 100 percent of 2017 Medicare rates for specialties previously protected by the Legislature (orthopedic, obstetric/gynecology, and neurosurgery).

Medicaid will reduce other specialties that are higher than Medicare rates to 90 percent of corresponding 2017 Medicare reimbursement rates. These two changes resulted in savings. Using those savings, Medicaid will increase the lowest reimbursed codes to 72.46 percent of 2017 Medicare fees. Additionally, the updated fee schedule includes new codes for 2017

and adjusts the legislatively required reimbursement rates to trauma providers.

Changes to the fee schedule are cost neutral. To view the January 1, 2017, fee schedule, select the 2017 fee schedule published on the website at dhmh.maryland.gov/providerinfo. Copies of the proposed changes are available for public review at the local health department in each county and Baltimore City. Written comments may be sent to Alison Donley, Office of Health Services, DHMH, 201 W. Preston St., RM 127C, Baltimore, MD 21201, or call at 410-767-6541 or email Alison.Donely@maryland.gov.

Contact: Nina McHugh (410) 767-5003

[16-26-29]

MARYLAND INSURANCE ADMINISTRATION

Subject: Public Hearing
Date and Time: January 9, 2017, 1 — 4 p.m.
Place: Maryland Insurance Administration, 200 St. Paul Pl., 24th Fl. Hearing Rm., Baltimore, MD
Add'l. Info: The Maryland Insurance Administration will conduct a public hearing on specific rate increase requests from the following Long-Term Care insurance carriers: Bankers Life and Casualty Company, John Alden Life Insurance Company, Senior Health Insurance Company of Pennsylvania, Physicians Mutual Insurance Company and Northwestern Long Term Care Insurance Company. The purpose of the hearing is for insurance company officials to explain their reasons for the rate increases. Commissioner Redmer will also listen to comments from consumers, producers and other interested parties at the hearing.

If you plan on attending, please RSVP to Nancy Muehlberger. Please also indicate if you plan on testifying at the hearing. Interested parties are also encouraged to submit written comments. Written comments and RSVPs should be sent to Nancy Muehlberger by January 6, 2017, either by email to Nancy.Muehlberger@maryland.gov or by mail to 200 St. Paul Place, Suite 2700, Baltimore, Md. 21202 or by fax to 410-468-2038.

Any questions regarding this matter should be directed to Nancy Muehlberger, Actuarial Analyst, by January 6, 2017, by email to Nancy.Muehlberger@maryland.gov. For more information on the hearing please see the following link:

http://insurance.maryland.gov/Consumer/Pages/Long-Term-Care-Hearing-January-9-2017.aspx.

Contact: Nancy Muehlberger (410) 468-2050

[16-26-06]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: January 19, 2017, 1 — 4 p.m.
Place: 4160 Patterson Ave., Rm. 100, Baltimore, MD
Contact: Valerie Wooding (410) 764-3460

[16-26-01]

MINORITY BUSINESS ENTERPRISE ADVISORY COMMITTEE

Subject: Public Meeting
Date and Time: January 11, 2017, 8:30 a.m. — 5 p.m.
Place: Maryland Dept. of Transportation, 7201 Corporate Center Dr., Hanover, MD
Contact: Sabrina Bass (410) 865-1240

[16-26-19]

MINORITY BUSINESS ENTERPRISE ADVISORY COMMITTEE

Subject: Public Meeting
Date and Time: January 25, 2017, 8:30 a.m. — 5 p.m.
Place: Maryland Dept. of Transportation, 7201 Corporate Center Dr., Hanover, MD
Contact: Sabrina Bass (410) 865-1240

[16-26-20]

MINORITY BUSINESS ENTERPRISE ADVISORY COMMITTEE

Subject: Public Meeting
Date and Time: February 8, 2017, 8:30 a.m. — 5 p.m.
Place: Maryland Dept. of Transportation, 7201 Corporate Center Dr., Hanover, MD
Contact: Sabrina Bass (410) 865-1240

[16-26-21]

MINORITY BUSINESS ENTERPRISE ADVISORY COMMITTEE

Subject: Public Meeting
Date and Time: February 22, 2017, 8:30 a.m. — 5 p.m.
Place: Maryland Dept. of Transportation, 7201 Corporate Center Dr., Hanover, MD
Contact: Sabrina Bass (410) 865-1240

[16-26-22]

MINORITY BUSINESS ENTERPRISE ADVISORY COMMITTEE

Subject: Public Meeting
Date and Time: March 8, 2017, 8:30 a.m. — 5 p.m.
Place: Maryland Dept. of Transportation, 7201 Corporate Center Dr., Hanover, MD
Contact: Sabrina Bass (410) 865-1240

[16-26-23]

MINORITY BUSINESS ENTERPRISE ADVISORY COMMITTEE

Subject: Public Meeting
Date and Time: March 22, 2017, 8:30 a.m. — 5 p.m.
Place: Maryland Dept. of Transportation, 7201 Corporate Center Dr., Hanover, MD
Contact: Sabrina Bass (410) 865-1240

[16-26-24]

DEPARTMENT OF NATURAL RESOURCES/FISHING AND BOATING SERVICES

Subject: Public Notice — Commercial Striped Bass Common Pool Gill Net Season Modification
Add'l. Info: The Secretary of Maryland Department of Natural Resources, pursuant to COMAR 08.02.15.12H, announces the opening of the 2016 commercial striped bass common pool gill net fishery on Tuesday, December 6, 2016, at 3 a.m. with a catch limit of 300 lbs/permit/week and 1200 lbs/vessel/day. The common pool fishery will close on Tuesday, December 6, 2016, at 11:59 p.m.
Mark J. Belton
Secretary of Natural Resources
Contact: Tamara O'Connell (410) 260-8271

[16-26-09]

RACING COMMISSION

Subject: Public Meeting
Date and Time: January 17, 2017, 12:30 — 1 p.m.
Place: Laurel Park, Laurel, MD
Contact: J. Michael Hopkins (410) 296-9682

[16-26-02]

RURAL HEALTHCARE DELIVERY WORKGROUP

Subject: Public Meeting
Date and Time: January 9, 2017, 11 a.m. — 3 p.m.
Place: Hodson Hall, 300 Washington Ave., Hynson Lounge, Chestertown, MD
Contact: Erin Dorrien (410) 764-3284

[16-26-03]

DEPARTMENT OF VETERANS AFFAIRS/MARYLAND VETERANS COMMISSION

Subject: Public Meeting
Date and Time: January 17, 2017, 10:30 a.m. — 1 p.m.
Place: 301 N. High St., Baltimore, MD
Contact: Denise Nooe (410) 260-3840
[16-26-04]

MARYLAND COLLEGE COLLABORATION FOR STUDENT VETERANS COMMISSION

Subject: Public Meeting
Date and Time: January 27, 2017, 12 — 1 p.m.
Place: UMBC, 1000 Hilltop Cir., Baltimore, MD
Contact: Denise Nooe (410) 260-3840
[16-26-12]

BOARD OF WELL DRILLERS

Subject: Cancellation of Public Meeting
Date and Time: December 28, 2016, 9 a.m. — 4 p.m.
Place: 1800 Washington Blvd., Baltimore, MD
Add'l. Info: This meeting has been canceled by the Board.
Contact: Elaine Nolen (410) 537-4466
[16-26-36]

DIVISION OF WORKFORCE DEVELOPMENT AND ADULT LEARNING/MARYLAND APPRENTICESHIP AND TRAINING COUNCIL

Subject: Public Meeting
Date and Time: January 10, 2017, 9 a.m. — 12 p.m.
Place: Maryland Dept. of Labor, Licensing, and Regulation, 1100 N. Eutaw St., Lower Level Training Rm., Baltimore, MD
Add'l. Info: The Apprenticeship and Training Council will consider the approval and registration of new apprenticeship programs, revisions to presently approved apprenticeship programs, and other business which may come before the Council.
Contact: Christopher D. MacLarion (410) 767-2246
[16-26-10]

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Last updated 12/2016
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06 Diseases
07 Hospitals
08 Health Facilities Grants

Part 2
09 Medical Care Programs

Part 3
10 Laboratories
11 Maternal and Child Health
12 Adult Health
13 Drugs
14 Cancer Control
15 Food
16 Housing
17 Swimming Pools and Spas
18 Human Immunodeficiency Virus (HIV) Infection and Acquired Immunodeficiency Syndrome (AIDS)
19 Dangerous Devices and Substances
20 Kidney Disease Program
21 Mental Hygiene Regulations
22 Developmental Disabilities

Part 4
23 Advance Directive Registry
24 Maryland Health Care Commission
25 Maryland Health Care Commission
26 Board of Acupuncture
27 Board of Nursing
28 Board of Examiners in Optometry
29 Board of Morticians and Funeral Directors
30 Maryland Commission on Kidney Disease
31 Health Occupation Boards
32 Board of Physicians
33 Board of Examiners of Nursing Home Administrators
34 Board of Pharmacy
35 Postmortem Examiners Commission
36 Board of Examiners of Psychologists

Part 5
37 Health Services Cost Review Commission
38 Board of Physical Therapy Examiners
39 Board of Nursing – Certified Nursing Assistants
40 Board of Podiatric Medical Examiners
41 Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists
42 Board of Social Work Examiners
43 Board of Chiropractic Examiners
44 Board of Dental Examiners
45 Maryland Community Health Resources Commission
46 Board of Occupational Therapy Practice
47 Alcohol and Drug Abuse Administration
48 Child Abuse and Neglect Medical Reimbursement Program
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54 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
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56 Board of Dietetic Practice
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60 Board of Environmental Health Specialists
61 Health Enterprise Zone Initiative
62 Natalie Laprade Medical Marijuana Commission
63 Community-Based Behavioral Health Programs and Services
64 Practice of Licensed Direct-Entry Midwives
65 Board of Massage Therapy Examiners

Title 11 Department of Transportation

Part 1
01 Office of the Secretary
02 Transportation Service Human Resources System
03 Maryland Aviation Administration
04 State Highway Administration
05 Maryland Port Administration
06 Mass Transit Administration
07 Maryland Transportation Authority
08 State Railroad Administration
09 Vacant
10 Vacant

Part 2
11 Motor Vehicle Administration – Administrative Procedures
12 MVA – Licensing of Businesses and Occupations
13 MVA – Vehicle Equipment
14 MVA – Vehicle Inspections
15 MVA – Vehicle Registration
16 MVA – Vehicle Operations
17 MVA – Driver Licensing and Identification Documents
18 MVA – Financial Responsibility Requirements
19 MVA – School Vehicles
20 MVA – Motorcycle Safety Program
21 MVA – Commercial Motor Vehicles
22 MVA – Preventive Maintenance Program
23 MVA – Drivers' Schools, Instructors & Driver Education Program

Title 26 Department of the Environment

Part 1
01 General Provisions
02 Occupational, Industrial, and Residential Hazards
03 Water Supply, Sewerage, Solid Waste, and Pollution Control Planning and Funding
04 Regulation of Water Supply, Sewage Disposal, and Solid Waste
05 Board of Well Drillers
06 Waterworks and Waste Systems Operators
07 Board of Environmental Sanitarians

Part 2
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09 Maryland CO_2 Budget Trading Program
10 Oil Pollution and Tank Management
11 Air Quality
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Part 3
13 Disposal of Controlled Hazardous Substances
14 Hazardous Substance Response Plan
15 Disposal of Controlled Hazardous Substances — Radioactive Hazardous Substances
16 Lead
17 Water Management
18 Susquehanna River Basin Commission

Part 4
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20 Surface Coal Mining and Reclamation under Federally Approved Program
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