



HealthChoice Covered Benefits and Services

The following listing of benefits was directly provided by the Department of Health and Mental Hygiene with the exception of editor's notes.

Overview

- ▶ MCOS must provide a complete and comprehensive benefits package that is equivalent (except for a few carve-out-services) to the benefits that have been available to Maryland Medicaid recipients throughout the Medicaid fee-for-service delivery system. Carve-out-services (which are not subject to capitation and are not a MCO's responsibility) are still available for Medicaid recipients. Medicaid will reimburse these services directly, on a fee-for-service basis.
- ▶ A HealthChoice Primary Care Provider (PCP) serves at the entry point for access to health care services. The PCP is responsible for providing enrollees with medically necessary and appropriate covered services, or, when appropriate, for referring an enrollee to a specialty area provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned enrollee.
- ▶ An enrollee has the right to access certain services without any prior referral or authorization by a PCP. This applies to self-referred services and, emergency services. The MCO is responsible for reimbursing out-of-plan providers who have furnished these services to the MCO's enrollees.
- ▶ Only benefits and services that are *medically necessary and appropriate* are covered.
- ▶ HealthChoice enrollees may not be charged any co-payments, premiums or cost sharing of any kind.
- ▶ Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program.

Covered Benefits and Services (Listed Alphabetically)

Blood and Blood Products

Blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.

Case Management Services

- Case management services are covered for enrollees who need such services including, but not limited to, members of special needs populations, which consist of the following non-mutually exclusive populations:
 - Children with special health care needs;
 - Individuals with a physical disability;
 - Individuals with a developmental disability;
 - Pregnant and post-partum women;
 - Individuals who are homeless;
 - Individuals with HIV/AIDS; and
 - Individuals with a need for substance abuse services.
- If warranted, a case manager will be assigned to an enrollee at the time of the initial health screen by the MCO.
- A case manager will perform home visits as necessary as part of the MCO's case management program, and will have the ability to respond to an enrollee's urgent care needs during this home visit.

Dental Services for Children and Pregnant Women

An MCO must cover dental services for enrollees who are younger than 21 years old, including:

- Semi Annual cleaning, fluoride treatment, examination;
- Emergency services;
- Diagnostic services;
- Preventive services;
- Treatment services;
- Pit and fissure sealants for occlusal surfaces of posterior permanent teeth that are without restoration or decay;
- Orthodontic care when the condition causes dysfunction and the case scores at least 15 points on the Handicapping Labio-Lingual Deviations Index No. 4; and
- General anesthesia when medically necessary and appropriate.

For enrollees who are at least 3 years old and under 21 years old, the following dental services are also covered:

Semiannual cleaning
Fluoride treatment
Examination

An MCO must also provide dental services to pregnant enrollees age 21 and older, including:

- Diagnostic services;
- Emergency services;
- Preventive services;
- Therapeutic dental services for oral diseases, including but not limited to:
- Emergency, preventive, diagnostic, and treatment services;
- One cleaning, fluoride treatment, and examination;
- Pit and fissure sealants for the occlusal surfaces of posterior permanent teeth that are without restoration or decay.

Diabetes Care Services

An MCO is required to cover all medically necessary and appropriate diabetes care services. An MCO must cover diabetes care services for enrollees who have been discharged from a hospital inpatient stay for a diabetes-related diagnosis that include:

- Diabetes nutrition counseling;
- Diabetes outpatient education;
- Diabetes-related durable medical equipment and disposable medical supplies, including:
 - Blood glucose meters for home use;
 - Finger sticking devices for blood sampling;
 - Blood glucose monitor supplies; and
 - Diagnostic reagent strips and tables used for testing ketone and glucose in urine and glucose in blood;
 - Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Dialysis Services

Enrollees in HealthChoice who suffer from End Stage Renal Disease (ESRD) are eligible for the Rare and Expensive Case Management. To be REM-eligible on the basis of ESRD, enrollees must meet one of the following sets of criteria:

- Children (under 21 years old) with chronic renal failure (ICD-9 code 585) diagnosed by a pediatric nephrologist; and
- Adults (ages 21-64) with chronic renal failure with dialysis (ICD-9 code 585 V45.1).

For those enrollees needing dialysis treatment who are enrolled in an MCO, dialysis services are covered, either directly by the MCO providing the service, or, at an enrollees's option, by MCO reimbursement of an out-of-plan provider to which an enrollee has self-referred.

Disposable Medical Supplies

Disposable medical supplies are covered, including incontinency pants and disposable underpads for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the enrollee.

Durable Medical Equipment

Durable medical equipment is covered when medically necessary and appropriate, including but not limited to all equipment used in the administration or monitoring of prescriptions by the enrollee. DME and/or DMS must be provided in a timely manner so as not to adversely affect the enrollee's health. Any preauthorization required by the MCO is required to be completed within 72 hours. If there is an urgent medical need (such as facilitating hospital discharge or enrollee's condition may suffer from delay), DME and/or DMS shall be provided within 24 hours. For other requests, DME and/or DMS must be provided within 7 days unless there is a documented reason that justifies additional time needed.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

For enrollees under 21 years of age, all of the following EPSDT services are covered:

- Well-child services provided in accordance with the EPSDT periodicity schedule by an EPSDT-certified provider, including:
 - Periodic comprehensive physical examinations;
 - Comprehensive health and developmental history, including an evaluation of both physical and mental health development;
 - Immunizations;
 - Laboratory tests including blood level assessments;
 - Vision, hearing, and dental screening; and
 - Health education.
- EPSDT partial or interperiodic well-child services and health care services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions, which services are sufficient in amount, and scope to treat the identified condition, and are subject to limitation only on the basis of medical necessity, including:
 - Chiropractic services;
 - Nutrition counseling;
 - Audiological screening and hearing aids when performed by PCP
 - Private duty nursing;
 - Durable medical equipment including assistive devices; and
 - Occupational, physical, and speech therapy services, for either habilitative or rehabilitative treatment, if the services are not delivered pursuant to an IEP or IFSP and provided in the schools or through Children's Medical Services community-based providers.

EDITOR'S NOTE: This does not mean that a child can only receive these therapies in a school setting. Please see the section on Getting Services Authorized in Managed Care. A problem or concern such a speech delay or fine motor deficit that presents across the day often does require more therapy than what may be provided in the school setting.

- Any other benefit listed in this section.
- MCO providers will be responsible for making appropriate referrals for publicly-funded programs not covered by Medicaid, Head Start, the WIC nutritional program, early

intervention services,; School Health-Related Special Education Services, vocational rehabilitation, and Maternal and Child Health Services (located at local health departments).

Family Planning Services

Comprehensive family planning services are covered, including:

- Office visits for family planning services;
- Laboratory tests including: pap smears when done as part of contraceptive management;
- Contraceptive devices; and
- Voluntary sterilizations.

Except for sterilization services, family planning services may be accessed, at an enrollee's option, either through the enrollee's PCP or by self-referral to an out-of-plan provider who is then reimbursed by the MCO.

HealthChoice Formulary Requirement

MCOs are required to expand their drug formularies to include new products approved by the Food and Drug Administration (COMAR 10.09.67.04D(3)) in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to prevent individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, new brand name drug rates as P (priority) by the FDA will be added to the formulary. Coverage may be subject to preauthorization to ensure the medical necessity and appropriateness for specific therapies. For formulary drugs requiring preauthorization by the MCO or its designee, a decision must be made within 72 hours after the initial request. If the service is denied, the MCO must notify the prescriber and the enrollee in writing of the denial (COMAR 10.09.71.02).

When a prescriber believes that a non-formulary drug is medically indicated, MCOs must have procedures in place for no-formulary requests (COMAR 10.09.67.04F(2)(a)). The Program expects a non-formulary drug to be approved if documentation is provided indicating the formulary alternative is not medically appropriate. Requests for non-formulary drugs cannot be automatically denied or delayed with repeated requests for additional information. The MCOs must follow an established reasonable review time for non-formulary requests to comply with the minimum performance standards for drug use management programs established by the Department.

HIV-Infected Individuals – (Case Management Services)

- Case management services are covered for any enrollee who is diagnosed with the human immunodeficiency virus. Case management will link HIV-infected enrollees with the full range of benefits covered by the MCO (e.g. substance abuse treatment, primary mental health care, and somatic health care services), as well as with any additional needed services, including, specialty mental health services, social services, financial services, educational services, housing services, counseling and other required report services.

- If an enrollee initially refuses HIV case management services, the services will still be available at any later time if requested by the enrollee.
- HIV case management services will be provided, with the enrollee's consent, to facilitate timely and coordinated access to appropriate levels of care, and to support continuity of care, across the continuum of qualified service providers. HIV case management services include:
 - Initial and ongoing assessment of the enrollee's needs and personal support systems, including using a multi-disciplinary approach to develop a comprehensive, individualized service plan;
 - Coordination of services needed to implement the plan;
 - Periodic re-evaluation and adaptation of the plan, as appropriate; and
 - Outreach for the enrollee and the enrollee's family by which the case manager and the PCP track services received, clinical outcomes and the need for additional follow-up.
 - The enrollee's case manager will serve as the enrollee's advocate to resolve differences between the enrollee's and the providers of care pertaining to the course or content of therapeutic interventions.

HIV-Infected Individuals – (Pharmacy)

There are several drugs used in treatment of HIV/AIDS that are not subject to capitation, nor are they the MCO's financial responsibility. Pharmacies providing these drugs to HealthChoice enrollees will receive direct reimbursement from Medicaid on a fee-for-service basis:

Invirase (saquinavir)
 Crixivan (indinavir)
 Norvir (ritonavir)
 Nevirapine (virmune)

Two classes of drugs used in the treatment of HIV/AIDS, (1) protease inhibitors and (2) non-nucleoside reverse transcriptase inhibitors, are available through direct provider reimbursement by the State on a fee-for-service basis. Any additional FDA approved drugs under these classes also will be directly reimbursed by Medicaid. Effective with the new rate structure January 1, 2001, all AIDS drugs will become the responsibility of the MCOs.

Home Health Services

Home health services are covered when the enrollee's PCP or attending physician certifies that the services are required on a part-time, intermittent basis by an enrollee who requires home visits. MCOs may choose to provide home health services to a non-homebound enrollee but this is not a mandatory benefit. Covered home health services are delivered in the enrollee's home and include:

- Skilled nursing services including supervisory visits;
- Home health aide services (including biweekly supervisory visits by a registered nurse in the enrollee's home, with observation of aide's delivery of services to enrollee at least every second visit);
- Physical therapy services;

- Occupational therapy services;
- Speech pathology services; and
- Medical supplies used in a home health visit.

Hospice Care Services

- Hospice care services, for enrollees who are terminally ill with a life expectancy of six months or less and who appropriately request the services are covered, are covered. Hospice services can be provided in a hospice facility, in another long-term care facility, or at home.

Hospice providers should inform their Medicaid enrollees (or patients applying for Medicaid coverage) as soon as possible after they enter hospice care about the MCO's with whom they contract so that enrollees can make an informed choice.

- DHMH will allow new enrollees who are in hospice to voluntarily change their MCO if they have been auto-assigned to a MCO with whom the hospice provider does not contract. If the new enrollee does not change their MCO, then the MCO in which the new enrollee is currently enrolled must pay the out-of-network hospice provider.
- Hospice providers should make enrollees aware of the option to change MCOs.

Inpatient Hospital Services

- Inpatient hospital services are covered.

When an enrollee is transferred to a long-term care facility and the length of the enrollee's stay is expected to exceed 30 days, the approval of the Department of Health and Mental Hygiene must be secured as soon as possible. Once an application for approval is filed, the Department will assess the admission's medical necessity and make a determination within 3 business days.

- For special rules for length of stay for childbirth (See Page 2.9).

Laboratory Services

Diagnostic services, and laboratory services performed by a CLIA-certified provider, are covered.

- Viral testing used in the treatment of HIV/AIDS, is not subject to capitation, nor is the MCO responsible for these procedures. The State directly reimburses the providers of these services on a fee-for-service basis.

Long-term Care Facility Services/Nursing Facility Services

- Long-term care facilities include chronic hospitals, rehabilitation hospitals, and nursing facilities (both skilled nursing facilities and intermediate care facilities).
- When an enrollee is transferred to a long-term care facility and the length of the enrollee's stay is expected to exceed 30 days, medical eligibility of the Department of

Health and Mental Hygiene (DHMH) for long term institutionalization must be secured as soon as possible.

The MCO is required to cover the first thirty days or until DHMH medical eligibility approval is obtained or whichever is longer. If required disenrollment procedures are not followed, the MCOs financial responsibility continues until the State 's requirements for the enrollee's disenrollment are satisfied.

- In order for an enrollee to be disenrolled from the MCO based on a long-term care facility admission, all of the following must occur:
- An application, DHMH 3871, for a Departmental determination of medical necessity has been filed (If a length of stay of more than 30 days is anticipated at the time of admission, the application should be filed at the time of admission).
- DHMH has to determine that the enrollee's long-term care facility admission was medically necessary and appropriate in accordance with the State's criteria.
- The enrollee's length of stay has to continue beyond 30 days.
- The MCO has filed an application for disenrollment with DHMH, including documentation of the enrollee's medical and utilization history, if requested.
- Assuming the recipient's continued Medicaid eligibility under long-term care criteria, once an enrollee has been disenrolled from the MCO, DHMH will directly reimburse a long-term care services provider.

EDITOR'S NOTE: Please see the full document for other information about these types of admissions.

Exceptions/Special Provisions:

- Inpatient acute care services provided within the first 30 days following admission to a long-term care facility is not considered an interruption of the 30 continuous days in a long-term care facility for which an MCO is responsible as long as the enrollee is discharged from the hospital back to the long-term care facility.
- Under federal requirements, an individual with serious mental illness (MI), or mental retardation (MR) or a related condition may not be admitted to a nursing facility (NF) unless the State determines that the NF services are appropriate.
- For each enrollee seeking NF admission, a Pre-admission screening and Resident Review (PASRR) ID Screen must be completed prior to NF admission.
- The first section of the ID Screen exempts an enrollee if NF admission is directly from a hospital for the condition treated in the hospital for the condition treated in the hospital and, the attending physician certifies prior to admission to the NF that the recipient is likely to require less than 30 days of NF services.
- If an enrollee is not exempted complete the ID Screen to identify whether the enrollee screens positive for MI or MR. If the enrollee screens negative refer to Adult

Evaluation and Review Services (AERS) located in the local health department for a STEPS assessment to help identify alternative services to NF placement. If the enrollee screens positive for MI or MR refer the enrollee to AERS for a PASRR evaluation. The evaluation will determine if NF is appropriate and if there is a need for specialized services, as defined in Nursing Home Transmittal No. 19. The State Mental Hygiene Administration or Development Disabilities Administration will give a final PASRR determination.

- If an enrollee is admitted into an Institution for Mental Disease (IMD), the MCO is responsible for an enrollee's somatic care during the first 30 consecutive days after admission, and during stays of less than 30 days, with an overall limit of a total of 60 days per calendar year, regardless of consecutiveness. The MCO's responsibility for an enrollee's somatic care would continue beyond 30 consecutive days, if the procedural requirements of institutionalization disenrollment (Department medical necessity determination and application for disenrollment, discussed above) were not followed and satisfied.
- An enrollee admitted to an Intermediate Care Facility – Mental Retardation (ICF-MR) is disenrolled from the MCO immediately upon admission to the facility, and the MCO retains responsibility for the enrollee's care.
- If an MCO places an enrollee in a licensed nursing facility, and the MCO disenrollment, the patient may transfer to a nursing home that accepts Medicaid payment.
- If an enrollee is admitted into an ICF-A, the MCO is responsible for medically necessary treatment for as many days as required even if care is a period greater than 30 days for recipients below the age of 21.

Outpatient Hospital Services

Medically necessary and appropriate outpatient hospital services are covered.

Outpatient Rehabilitative Services

Outpatient rehabilitative services, including physical therapy, occupational therapy, and speech therapy, are covered. For enrollees under age 21, payments for these services should be billed fee-for-service to the Department.

Oxygen and Related Respiratory Equipment

Oxygen and related respiratory equipment are covered.

Pharmacy Services

- Pharmaceutical services and pharmaceutical counseling ordered by an in-plan provider, by a provider to whom the enrollee has legitimately self-referred (if provided on-site), or by an emergency medical provider are covered, including:
 - Legend (prescription) drugs;
 - Insulin;
 - Contraceptives;
 - Latex condoms (to be provided without any requirement for a provider's order);
 - Hypodermic needles and syringes;
 - Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, Jejunostomy, or gastrostomy tube;
 - Enteric coated aspirin prescribed for treatment of arthritic conditions;
 - Nonlegend ferrous sulfate oral preparations;
 - Nonlegend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for enrollees under age 12;
 - Formulas for genetic abnormalities;
 - Medical supplies for compounding prescriptions for home intravenous therapy;
 - Psychotropic drugs prescribed in connection with the provision of primary mental health care services, within the prescriber's scope of practice. (There are ten therapeutic classes of drugs on the mental health formulary for which some percentage of the dollars have been included in the MCO rates. Effective January 1, 2001 with the new rate structure, most mental health drugs will be paid for fee-for-service except drugs on Attachment III-A which will be the responsibility of the MCO); and
 - Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for an enrollee by a qualifying provider.

The MCO performs drug utilization review pursuant to its drug review utilization program, which is subject to review and approval by DHMH, and is coordinated with the drug utilization review program of the Specialty Mental Health Service delivery system.

- Limitations: neither the State nor the MCO cover any of the following:
 - Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight; or
 - Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition.

Physician and Advanced Practice Nurse Specialty Care Services

- Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when services are medically necessary and appropriate and are outside of the PCP's scope of practice, or are of a type that the PCP does not customarily provide, it is not specifically trained for, or is not experienced in providing.
- Specialty care services covered under this section also include:

- Services performed within their scope of practice to assist in the provision of specialty care services by non-physician, non-APN practitioners employed by a physician, and working under the physician's direct supervision; and
- Services provided in a clinic by or under the direction of a physician or dentist; and
- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians.

Podiatry Services

Podiatry services are covered. See routine care in limitation section.

Pregnancy-related Services

Pregnancy-related services are covered, including:

- Comprehensive prenatal, Perinatal, and postpartum care (including high-risk specialty care);
- Prenatal risk assessment and completion of the Maryland Prenatal risk Assessment form (DHMH 4850);
- Development of an individualized plan of care, which is based upon the risk assessment and is appropriately modified during the course of care;
- Case management services;
- Prenatal and postpartum counseling and education;
- Basic nutritional education;
- Smoking cessation education;
- Special substance abuse treatment;
- High-risk nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women;
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers; and
- Post-natal home visits (see specific information below).

Pregnancy-related services providers will follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines.

The PCP, OB/GYN, or MCO, as applicable, is responsible for the following:

Completion of the Maryland Prenatal Risk Assessment form (DHMH 4850) for each pregnant enrollee at her first prenatal appointment:

Within 10 days of the initial prenatal visit, forwarding all completed Maryland Prenatal Risk Assessments to the local health department in the jurisdiction in which the enrollee lives; and

Making referrals at any time during the pregnancy to the local health department's Healthy Start Program in the enrollee's jurisdiction for any enrollee identified as being at risk for psychosocial problems. (After a referral to the Healthy Start Case Management program, the provider still retains responsibility for the enrollee's treatment.)

Special rules for length of stay following childbirth:

- An enrollee's length of stay after childbirth is determined in accordance with the Guidelines for Perinatal Care (American College of Obstetricians and Gynecologists and the American Academy of Pediatrics), unless the 48 hour (uncomplicated vaginal delivery)/96 hour (uncomplicated cesarean section) length of stay guaranteed by State law is longer than that required under the Guidelines.
- If an enrollee must remain in the hospital after childbirth for medical reasons, and she requests that her newborn remain within the hospital while she is hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.
- If an enrollee elects to be discharged earlier than the conclusion of the length of stay guaranteed by State law, a home visit must be provided.

When an enrollee opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery; before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider are covered;

If an enrollee remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider is covered.

Post-natal home visits are to be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a mother and newborn, and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse symptoms of the newborn;
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother;

- Blood collection from the newborn for screening, unless previously completed;
- Appropriate referrals; and
- Any other nursing services ordered by the referring provider.

The PCP, OB/GYN, or MCO is responsible for making appropriate enrollees to publicly-provided services that may improve pregnancy outcome. Examples of such appropriate referrals include the WIC special supplemental nutritional program and the local health departments' Healthy Start Case Management program. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

Primary Care Services

Primary Mental Health Services are provided by the MCO.

- The MCO covers primarily mental health services required by enrollees, including clinical evaluation and assessment, provision of primary mental health services, and/or referral for additional services, as appropriate.
- The PCP of an enrollee requiring mental health services may elect to treat the enrollee, regardless of the diagnosis and severity of the illness, if the treatment falls within the scope of the PCP's practice, training, and expertise. Neither the PCP nor the MCO may bill the Public Mental Health System (PMHS) for the provision of such services because these services are included in the MCO's HealthChoice capitation rates.
- When, in a PCP's judgement, an enrollee's need for mental health treatment cannot be adequately addressed by primary mental health services provided by the PCP, the PCP should, after determining the enrollee's eligibility (based on probable diagnosis), refer the enrollee to the SMHS for specialty services. (This process is described in the following section.)

Primary care is generally received through an enrollee's Primary Care Provider (PCP), who acts as a primary coordinator of care, and has responsibility to provided accessible, continuous, comprehensive, and coordinated health care services covering the full range of benefits for which an enrollee is eligible. In some cases, enrollees will opt to access certain primary care services by self-referral to providers other than their PCPs, for example, to school-based health centers or family providers. Primary care services include:

- Addressing the enrollee's general health needs;
- Coordination of the enrollee's health care;
- Disease prevention promotion and maintenance of health;
- Treatment of illness;
- Maintenance of enrollees' health records; and
- Referral for specialty care.

Substance Abuse Treatment Services

Substance abuse treatment services are covered. See page 2-13. including:

- Substance abuse screening, comprehensive assessment, and placement appraisal, all provided by the MCO and performed by a qualified provider using an appropriate instrument:
- Outpatient substance abuse treatment, including methadone maintenance (provided by MCO = "MCO");
- Detoxification treatment (outpatient, or, if medically necessary, inpatient) (MCO);
- Intermediate Care Facility-Alcoholic (ICF-A) inpatient treatment for enrollees younger than age 21, (MCO), and for enrollees ages 21 and older whose Medicaid eligibility is based on receiving Temporary Cash Assistance (TCA) (provided by Medicaid program – on a fee-for-service basis (MFFS).
- Long-term residential care program ("group home") for TCA parents under age 18 (MFFS).
- Halfway house for TCA parents ages 18-20 (inclusive), and for TCA enrollees ages 21 and older (MFFS)
- Residential drug-free treatment program ("therapeutic community") for TCA parents ages 18-20 (inclusive), and for TCA enrollees ages 21 and older (MFFS).

For pregnant and postpartum substance-abusing enrollees:

Access to treatment within 24 hours of request;
Case management; and
Intensive outpatient programs, including day treatment that allows for children to accompany their mother.

Individuals with HIV/AIDS who are substance abusers will receive substance abuse treatment within 24 hours of request.

Vision Care Services

Medically necessary and appropriate vision care services are covered.

- An MCO is responsible to provide:
- One (1) eye examination every 2 years for enrollees age 21 and older.
- For enrollees under 21, at least one (1) eye examination every year in addition to EPSDT screening, one (1) pair of eyeglasses per year unless lost, stolen, broken, or no longer vision and contact lenses, if eyeglasses are not medically appropriate for the condition.

Benefit Limitations

The following are not covered under HealthChoice:

- Experimental or investigational services.
- Services that are not medically necessary and appropriate.
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state).
- Services that are beyond the scope of practice of the health care practitioner performing the service.
- Autopsies.
- Immunizations for travel outside the U.S.
- Transportation services provided through grants to local governments, other than assisting enrollees to secure non-emergency transportation through their local governments. An MCO must provide non-emergency transportation to access a covered service if the MCO chooses to provide the service at a location that is outside of the closest county in which the services is available;
- Abortions. (But available under limited circumstances through Medicaid fee-for-service.)
- Diet and exercise programs for the loss of weight except when medically necessary and appropriate.
- In vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- Covered benefits for recipients travelling outside the United States.
- Ovulation stimulants.
- Reversal of voluntary sterilization procedure.
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities.
- Lifestyle improvements (physical fitness programs, nutrition counseling, smoking cessation) unless specifically included as a covered service.
- Non-medical ancillary services (vocational rehabilitation, employment counseling, or educational therapy).

- Private hospital room unless medically necessary.
- Private duty nursing for adults 21 years old and older;
- Dental services, other than for enrollees who are either younger than 21 years old or are pregnant, unless voluntarily covered by the MCO.
- Orthodonture except when
 - The enrollee is under 21 years of age; and
 - The case scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction;
 - Piped-in oxygen or oxygen prescribed for standby purposes or on as-needed basis.
 - Therapeutic footwear other than for an enrollee who qualifies for diabetes care services or for an enrollee who is younger than 21 years old.
- Routine foot care, except for chronic or continued podiatry care for enrollees who are diabetic or who have a vascular disease affecting the lower extremities or are younger than 21 years old.
- Non-legend drugs other than insulin and enteric coated aspirin for arthritis.
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the enrollee is younger than 12 years old.
- Purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, other than for enrollees younger than 21 years old.
- Services performed before the effective date of the enrollee's coverage.

Medicaid Covered Services Not Covered by the MCO But Available Through Medicaid Fee-for-Service Reimbursement or other Publicly-Funded Programs.

- Occupational therapy, Physical therapy, Speech therapy or Audiology for children under the age of 21 years old.
- ICF-MR services – Intermediate care facilities – mental retardation services are available through State facilities.
- Medical day care services are available through direct provider reimbursement by the State on a fee-for-service basis.
- Personal care services are available through direct provider reimbursement by the State on a fee-for-service basis.

Medicaid Covered Services Not Covered by the MCO But Available Through Medicaid Fee-for-Service Reimbursement or other Publicly-Funded Programs. (cont.)

- Viral load testing (diagnostic services), genotypic, phenotypic, or other HIV/AIDS resistance testing and specified drugs used in the treatment of HIV/AIDS, as well as two drug classes used in the treatment of HIV/AIDS, (1) protease inhibitors and (2) non-nucleoside reverse transcriptase inhibitors, are available through direct provider reimbursement by the State on a fee-for-service basis. Effective January 1, 2001, the drug classes in HIV/AIDS treatment are to be reimbursed by the MCO.
- Specialty mental health services (See Section IV, Public Mental Health Services).
- After an enrollee's MCO institutionalization in a chronic hospital, rehabilitation hospital, skilled nursing facility, intermediate care facility or Institution for Mental Disease (IMD).
- Health-related services are targeted case management services provided to children when the services are specified in the child's Individualized Family Service (ISFP) of Individualized Education Plan (IEP) and provided in the schools or by community-based children's medical service providers.
- Healthy Start Case Management Services delivered by Local Health Departments.
- Special support services for individuals with developmental disabilities, under the DD waiver.
- Residential substance abuse treatment for qualifying enrollees whose Medicaid eligibility is based on receipt of Temporary Cash Assistance (TCA):
 - For TCA parents under age 18: long term residential care program (group home);
 - For TCA parents ages 18-20 (inclusive): halfway house, residential drug-free treatment program (therapeutic community); and
 - For TCA ages 21 and older: halfway house, residential drug-free treatment program (therapeutic community) and ICF-A.
- Abortions meeting specific conditions consistent with the terms of the annual budget bill, i.e., only when one of the following sets of circumstances apply: pregnancy likely to result in the death of the woman; woman a victim of officially reported rape, sexual offense, or incest; fetus affected by genetic defect or serious deformity or abnormality; substantial risk of pregnancy's serious and adverse effect on the woman's present or future physical health or a serious present effect and serious or long lasting effect on the woman's future health. Provider reimbursement is covered by the site on a fee-for-service basis.

Self-Referral Services

Some covered services, which are subject to capitation, may, at an enrollee's option, be delivered by an out-of-plan provider at the MCO's expense. The services that an enrollee has the right to access on a self-referral basis include:

- Certain family planning services including office visits, diaphragm fitting, IUD insertion and removal, special contraceptive supplies, Norplant, Norplant insertion and removal, depo provera-FP, latex condoms, and PAP smear;
- Certain school-based health center services, including treatment and one uncomplicated follow-up visit for up to four acute somatic illnesses per semester, and the family planning services listed above;
- Initial medical examination for a child in State-supervised care;
- Unless the MCO provides for a service before a newborn is discharged from the hospital, the initial examination of a newborn before discharge, if performed by an out-of-network on-call hospital provider;
- Annual Diagnostic and Evaluation Service (DES) visit for an enrollee diagnosed with HIV or AIDS;
- Continued obstetric care with her pre-established provider for a pregnant enrollee;
- Renal dialysis services; and
- Pharmaceutical and laboratory services, when provided in connection with a legitimately self-referred service, provided on-site where the self-referred services were performed, and by the same out-of-plan provider.
- A new enrolled child with a special health care need may continue to receive medical services directly related to the child's mental condition under a plan of care that was active at the time of the child's initial enrollment, if the child's out-of-plan provider submits the plan of care to the MCO for review and approval within 30 days of enrollment (For additional information, see Page 1-2).
- MCO enrollees may directly seek a comprehensive substance abuse assessment (CSAA) without preauthorization. The MCO is responsible for paying for the CSAA only if the following conditions are met:
 - Recipient is not in substance abuse treatment.
 - Recipient has not had a CSAA during the same calendar year, and
 - The assessment provider is an ADAA certified substance abuse provider who is qualified to administer the ASI or POSIT, and the ASAM.