MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
MCO Transmittal No. 124
January 25, 2018

TO: Managed Care Organizations

FROM: Susan J. Tucker, Executive Director, Office of Health Services

RE: MCO Request to Disenroll Members who Move Out-of-State

NOTE: Please ensure that the appropriate staff members in your organization are informed of the content of this transmittal.

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This transmittal informs MCOs about the new process requiring MCOs to notify the Department when they have credible information that a HealthChoice enrollee no longer permanently resides in Maryland. This transmittal supersedes MCO Transmittal #33.

Members who move outside Maryland are no longer eligible for HealthChoice. Effective 2/1/18, MCOs must complete the HealthChoice Recipient Moved Out of State or Return Mail Reporting Form (attached) and submit the form to the HealthChoice Enrollment Unit (HCEU) within 10 days of receiving credible information that an enrollee is no longer residing in Maryland. The MCO must inform the Department of the specific reason it believes the enrollee is no longer residing in Maryland. Claims for services provided to an enrollee at an out-of-State hospital/facility alone are not sufficient by themselves to conclude that a member now resides permanently out-of-State.

When the Department receives notification from an MCO, the enrollee will be issued an unscheduled eligibility notice. If the enrollee fails to provide evidence that they permanently reside in Maryland within 10 days, the member's Medicaid eligibility and MCO enrollment will close the end of the month in which the 10-day period ends.

Questions about this transmittal should be addressed to Shirley.Maas@maryland.gov/ (410) 767-5451 or Rosemary.Vranish@maryland.gov/ (410) 767-5325.

HEALTHCHOICE RECIPIENT(S)
MOVED OUT OF STATE OR RETURN MAIL REPORTING FORM

MOVED OUT OF STATE- Complete this form ONLY when MCO has credible information that a recipient no longer resides in the State of Maryland. Please note, the address on an out of state hospital bill may be a temporary address and is not proof that a recipient has moved out of state. MCOs must document they have verified a recipient's residential status before submitting out of state hospital/facility bills. For all other address changes, the recipient must report the change to the Maryland Health Connection, their local DSS or health department depending on where the recipient applied for Medicaid.

RETURN MAIL- Complete this form ONLY when MCO has a new address for a recipient who was listed on the return mail project file (if possible please try to confirm that the address you are reporting is still correct prior to completing form) or the MCO can document the recipient has received services (e.g. medical, pharmacy, referral for services) within 60 days of mail return. The form must be submitted for processing at least 5 business days prior to intended disenrollment date.

Please submit the completed form via one of the following methods:

Email: Send via secure messaging to mdh.hcenrollment@maryland.gov
FAX: 410-333-7141
MAIL: Maryland Department of Health
Beneficiary Enrollment Services
Room L-9
201 W. Preston Street
Baltimore, MD 21201

DATE: _____ MCO Name: _____

MCO Contact: _____Email_____

Phone: _____

Head of Household Name: _____ _____ ___
(Last) (First) (M.I.)

Head of Household Medical Assistance #: _____

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PART 1- Recipient Address Information

Current Street Address:_____

City: _____ Phone:_____

State:_____ Zip Code:_____

New Street Address (if applicable):_____

City: _____

State or Country:_____ Zip Code: _____

Date Address Change was reported to MCO:_____

Address Change Reported By:_____Relationship:_____

Please provide specific details as to why you believe the recipient does not reside in Maryland?

PART 2- To be completed only if the recipient does NOT have a new address but MCO has documentation that recipient received services within the last 60 days. Please indicate service rendered below and attach supportive documentation.

☐ medical ☐pharmacy ☐other_____

Revised 1/3/18

For Internal Purposes Only

Recipient in ☐ CARES or ☐ HBX Case referred to _____on _____