MEDICAL CARE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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MARYLAND MEDICAL ASSISTANCE PROGRAM
HealthChoice Transmittal No. 1
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Managed Care Organizations

FROM: Joseph M. Millstone, Director
Medical Care Policy Administration

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

On-going Treatments and Health Care Services for New HealthChoice Enrollees

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The HealthChoice Program was carefully designed to ensure that Medicaid members receive medically necessary and appropriate services. As part of this design, each MCO is responsible for providing on-going treatments and patient care to new recipients until the MCO completes an initial evaluation and develops a new plan of care. From prior discussions, I know that each MCO agrees that this is the MCO's responsibility.

The following steps need to be taken to ensure that recipients continue to receive necessary health care services as they become members of MCOs:

I Appropriate service referrals to specialty care providers need to be provided to your members in a timely fashion in order to ensure that all necessary health services are continued without interruption.

2. Authorization for these on-going services cannot be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those that

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members were receiving upon entrance into the MCO need to be continued during this transition period.

3 If after the member receives a comprehensive assessment the MCO determines that a reduction in services is warranted, the MCO must notify the recipient of this change at least ten days before it is implemented. This notification must tell the member that he/she has the right to formally complain to the Department by calling the HealthChoice Enrollee Action Line. In addition, the notice must explain the fact that if the member complains within ten days of the MCO notification, then the MCO must continue to provide these services until the Department decides whether the change is appropriate. The providers involved should also be sent a copy of this same notification.

4. If the member complains within 10 days of the MCO's notification, then the MCO must continue to provide the services until the Department decides whether the change is appropriate. If the Department determines that the member is indeed entitled to the original level of service, then the Department will notify the MCO of this decision and the MCO must continue to provide those services. The MCO may appeal the Department's decision if it so chooses. If the Department decides that the MCO is correct, then the Department will notify the member, in writing, that the Department upholds the MCO's decision. This notification will also give the member the right to appeal the Department's decision.

5 If the member appeals within 10 days of the notification, then services are again continued through the fair hearing process. The MCO is responsible for paying for all benefits required to be continued in numbers 3, 4, and 5, unless the MCO appeals the Department's order to continue services and wins in the fair hearing process.

While it is important that all members receive continuity of care, it is particularly crucial for Special Needs Populations. Assuring and maintaining quality of care must be our highest priority. Thank you for your prompt attention to this matter.