HEALTHCHOICE MANAGED CARE ORGANIZATION AGREEMENT

THIS AGREEMENT (Agreement), effective January 1, 2024, is entered into by and between the Maryland Department of Health (MDH) and _____(MCO), a Managed Care Organization with authority to conduct business in the State of Maryland (State).

WHEREAS, MDH has established the Maryland Medicaid Managed Care Program, also known as the Maryland HealthChoice Program (HealthChoice), a waiver program approved by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) under §1115 of the Social Security Act and authorized under Maryland Annotated Code, Health-General Article, §§15-101 et seq.

WHEREAS, MDH desires to provide health care services to Medicaid recipients through the MCO.

WHEREAS, the MCO is engaged in the business of arranging and/or providing health care services.

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained, the parties hereto agree as follows:

I. DEFINITIONS AND ACRONYMS

A. For the purposes of this agreement, the following terms have the meaning stated:

1. "Administrative Services Organization" means an organization that manages designated administrative functions while the entity contracting the organization retains the risks and liabilities.

2. "Biomarker Companion Diagnostic Test" means a test used to determine if a specific medication/therapy will be more effective in treatment, thereby guiding clinical management.

3. "CenteringPregnancy services" means group prenatal care provided by a practice approved, or in the process of obtaining approval, by the Centering Institute.

4. "Collaborative Care Model" means an evidence-based approach for integrating physical and behavioral health services in primary care settings that includes care coordination and management; regular systematic monitoring and treatment using a validated clinical rating scale; and regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement.

5. "CRISP" means the designated regional health information exchange that serves Maryland and the District of Columbia.

6. “Direct and indirect remuneration fees” in PBM contracts may include but are not limited to:

   A. Any pay-to-play for network participation;

   B. Any fees for periodic reimbursement reconciliations to provide a true-up between a target reimbursement rate in a participating pharmacy agreement and the aggregated effective rate actually realized by a pharmacy or between the aggregate maximum allowable cost (MAC) or adjudicated rate and the aggregate contracted rate; or

   C. Any payment mechanism to pharmacies for the fulfillment of quality measures or fee assessed to pharmacies for noncompliance with quality measures.

7. “Encounter Data” means information documenting a service to an Enrollee.

8. “Enrollee” means a Medicaid recipient who is enrolled in a managed care organization.

9. “Gender-affirming treatment” means any medically necessary treatment consistent with current clinical standards of care prescribed by a licensed health care provider for the treatment of a condition related to the individual’s gender identity.

10. “HealthySteps services” means enhanced pediatric primary care provided by a practice approved, or in the process of obtaining approval, by Zero to Three.

11. "Iatrogenic infertility” means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.

12. “MDH” means the Maryland Department of Health, as defined in COMAR 10.09.36.01, or its authorized agents acting on behalf of MDH.

13. “Medically necessary services” means that the service or benefit is:

   A. Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

   B. Consistent with current accepted 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 consumer, the consumer's family, or the provider.

14. “Medical loss ratio” means a formula that measures the ratio of MCO spending on medical and related benefits compared to revenue, to ensure that MCOs are spending a sufficient amount of their premium revenue on medical expenses and other high-impact initiatives.

15. “MLR reporting year” means a period of 12 months consistent with the rating period selected by MDH.

16. “Network provider” means a provider that is a member of the MCO’s provider panel. A network provider is not a subcontractor on the sole basis of its network provider agreement with the MCO.

17. “Pharmacy benefit manager” means a third-party administrator of a prescription drug program for an MCO, including but not limited to network management, drug utilization review, outcome management, and disease management.

18. “Potential enrollee” means a recipient who is authorized by MDH to enroll in a managed care organization.

19. “Practice guidelines” means statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

20. “Program” means the Medical Assistance Program.

21. "Recipient” means an individual who receives benefits under the State Medical Assistance Program.

22. "Self-referral services" are the health care services listed in COMAR 10.67.06.28 for which, under specified circumstances, the MCO is required to pay, without any requirement of referral by the PCP or MCO, when the enrollee accesses the service through a provider other than the enrollee's PCP.

23. “Spread pricing” means a form of reimbursement in which the pharmacy benefits manager (PBM) retains the difference between the amount the MCO pays the PBM and the amount the PBM reimburses the pharmacy for a drug and its associated costs. Spread pricing does not include the MCO paying the PBM reasonable administrative and transactional costs for services.

24. "Standard fertility preservation procedures” means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for

Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

25. "State" means the State of Maryland.

26. "State Plan" means an agreement between the State and the Federal government describing how the State administers its Medicaid and CHIP programs. The State Plan includes the groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities underway in the State.

27. "Subcontractor" means an individual or entity that has a contract with an MCO that relates directly or indirectly to the performance of the MCO's obligations under this contract. A network provider agreement with an MCO does not by itself make the network provider a "subcontractor" to an MCO.

28. "Third party liability" means the legal obligation of third parties (for example, certain individuals, entities, insurers, or programs) to pay part or all the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

B. For the purposes of this agreement, the following terms will be addressed using the stated acronym:

1. ACA – Affordable Care Act
2. ASO – Administrative Services Organization
3. CoCM – Collaborative Care Model
4. COMAR – Code of Maryland Regulations
5. CMS – Centers for Medicare and Medicaid Services
6. CRISP – Chesapeake Regional Information System for our Patients
7. DHHS – U.S. Department of Health and Human Services
8. DPP – Diabetes Prevention Program
9. EMS – Emergency Medical Services
10. EPLS – Excluded Parties List System
11. E&M – Evaluation and Management
12. ePREP – Electronic Provider Revalidation and Enrollment Portal

13. FFS – Fee-for-Service
14. FQHC – Federally Qualified Health Center
15. HEDIS – Healthcare Effectiveness Data and Information Set
16. HSCRC – Health Services Cost Review Commission
17. IRO – Independent Review Organization
18. LEIE – List of Excluded Individuals/Entities
19. MCO – Managed Care Organization
20. MHBE – Maryland Health Benefit Exchange
21. MLR – Medical Loss Ratio
22. M-QIP – Maryland Quality Incentive Program
23. NCQA – National Committee for Quality Assurance
24. NDC – National Drug Code
25. NPPES – National Plan and Provider Enumeration System
26. OIGH – Office of the Inspector General for Health
27. PBM – Pharmacy Benefit Manager
28. PHIP – Population Health Incentive Program
29. SSA-DMF – Social Security Administration Death Master File
30. TPL – Third Party Liability
31. TTY/TDD – Teletypewriter/Telecommunication Device for the Deaf
32. URAC – Utilization Review Accreditation Commission
33. WPATH – World Professional Association for Transgender Health

II. THE MCO AGREES:

A. General Requirements

1. To comply with Maryland Annotated Code Health-General Article, Title 15 and the Insurance Article provisions referenced therein, the regulations of the HealthChoice Program (see Appendix S), several of which are specifically referenced herein, as well as 42 CFR Part 438, any other applicable provisions of federal law, the Maryland Code, COMAR, transmittals, and guidelines issued by MDH in effect at any time during the term of this Agreement.

2. Notwithstanding any other provision of this Agreement, to be subject to any change in Federal or State law or regulation, or other policy guidance from CMS or MDH that applies during the term of this Agreement. The MCO retains all rights available to challenge the authority or basis for any such changes.

3. To comply with the federal law provisions pertaining to Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), The Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 as amended, and section 1557 of the Patient Protection and Affordable Care Act, as well as the conflict of interest safeguards described in 42 CFR 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

4. To comply with the requirements of section 5006 of the American Recovery and Reinvestment Act and all applicable federal guidance regarding the rights of Indian Enrollees.

5. To comply with the MCO's continuity of operations plan and disaster recovery plan, along with any directives from the State or MDH, in the event of a state of emergency (or other catastrophic event). This requirement includes keeping up to date the continuity of operations plan and disaster recovery plan, providing the plans to MDH upon request, and ensuring subcontractors maintain and deploy routinely updated continuity of operations plans and disaster recovery plans when necessary.

6. To execute the most recent State Providers' Amendment to HealthChoice Provider Service Agreements whenever the MCO executes or amends a HealthChoice Provider Service Agreement with a local health department.

7. To comply with the provisions of this Agreement and all appendices contained therein.

8. To execute the Non-Exchange Entity Agreement with the Maryland Health Benefit Exchange (MHBE) and ensure the confidentiality, privacy and security of data accessed by the MCO or exchanged between the MCO and MHBE and compliance with the requirements of the ACA, including 45 CFR 155.260(b)(2) and 45 CFR 155.270(a).

9. To participate in federal grants awarded to MDH and federal grant application processes.

B. **Enrollment & Disenrollment**

1. To accept enrollments of recipients authorized to enroll into an MCO by MDH and process enrollments in accordance with 42 CFR 438.54 and COMAR 10.67.02.02 (Appendix S).

2. To accept enrollment of recipients who are pregnant but would otherwise not be eligible for services due to their immigration status, as required by the Healthy Babies Equity Act (Md. Code Ann. Health-General Art. 15-103(a)(3)(xviii)).

3. To request disenrollment only for the reasons set forth in COMAR 10.67.02.06D (Appendix S) and 42 CFR 438.56.

4. To comply with MDH's disenrollment policies and procedures, which are set forth in COMAR 10.67.02.05, 10.67.02.06, and 10.09.69.04 (Appendix S).

5. To submit to MDH, within thirty (30) days of the date the MCO receives the monthly enrollment listings from MDH, a list of Enrollees who are known to the MCO to have:

   A. Disenrolled from the HealthChoice Program;

   B. Relocated to a geographic area not serviced by the MCO;

   C. Become ineligible to receive HealthChoice Program services from the MCO; or

   D. Died.

6. To submit any additional information MDH requests about the Enrollees referenced in II.B.4 of this Agreement.

7. To process Enrollee updates provided by MDH in a timely manner, including but not limited to Enrollee demographic updates and Enrollee primary care provider selections.

8. To comply with MDH's Covid-19 public health emergency unwinding policies and procedures, including:

   A. Conducting outreach to disenrolled individuals during the 120-day reconsideration period; and,

   B. Assisting Enrollees with renewal applications per the Section 1902(e)(14)(A) waiver held by MDH.

C. **Enrollee Rights**

1. To permit each Enrollee to choose his or her network provider to the extent possible and appropriate, as set forth in COMAR 10.67.05.05 (Appendix S).

2. To provide practice guidelines to Enrollees and potential Enrollees upon request.

3. To accord Enrollees all the rights available to them under 42 CFR 438.100; to require their network providers to also respect those rights; and to develop written policies governing the protection of those rights.

4. To refrain from discriminating against or using any policy or practice that has the effect of discriminating against Enrollees based on age, sex, gender identity, race, creed, color, marital status, sexual orientation, national origin, physical or mental handicap, health status, or need for health services.

5. Not to prohibit or otherwise restrict the advice that a health care professional, with a contractual, referral, or other arrangement with the MCO, gives to an Enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under this Agreement, if the professional is acting within the lawful scope of practice.

6. To comply with the requirements governing Enrollee appeals and grievances set forth in COMAR 10.67.09 (Appendix S) and 42 CFR 438, subpart F.

7. To provide the MCO enrollee services phone number on the identification card required in COMAR 10.67.04.02E (3).

D. **Covered Services**

1. To cover, for Enrollees:

A. In accordance with COMAR 10.67.06 and as defined in COMAR 10.67.01.01B (Appendix S), medically necessary covered services under the Maryland Medicaid State Plan (State Plan) in the amount, duration and scope set forth in the State Plan and in accordance with 42 CFR 438.210 and 42 CFR 440.230.

B. Any services that the MCO voluntarily agrees to provide, the cost of which cannot be included when determining the payment rates under this Agreement.

C. Any services necessary for compliance by the MCO with the requirements of subpart K of 42 CFR Part 438, to the extent such services are necessary for the MCO to comply with 42 CFR 438.910.

D. CenteringPregnancy services for pregnant and postpartum individuals as part of MCO-covered pregnancy-related benefits.

E. HealthySteps services for Enrollees ages 0-3 as part of MCO-covered pediatric benefits.

F. Gender-affirming treatment that includes but is not limited to:

   i. Hormone therapy, hormone blockers, and puberty blockers;

   ii. Hair alteration for the purposes of altering secondary sex characteristics and surgical site preparation;

   iii. Alterations to voice, voice therapy, and voice lessons;

   iv. Alterations to abdomen, chest, trunk, and buttocks;

   v. Alterations to the face and neck;

   vi. Alterations to the genitals and gonads;

   vii. Laser treatment for scars from gender-affirming treatment;

   viii. Standard fertility preservation procedures as set forth in Md. Code Ann. Ins. § 15-810.1;

   ix. Revisions to previous treatments and reversal of treatments;

   x. Combinations of gender-affirming treatments;

   xi. Other treatments as prescribed to suppress the development of endogenous secondary sex characteristics, align the individual's appearance or physical body with gender identity, and alleviate symptoms of clinically significant distress resulting from gender dysphoria; or,

   xii. Treatment described in the current clinical standards of care for gender-affirming treatment published by WPATH.

G. Standard fertility preservation procedures in connection with gender-affirming treatment, iatrogenic infertility, or medical treatment that may directly or indirectly cause iatrogenic infertility that include:

   i. Sperm and oocyte cryopreservation and evaluations;

   ii. Laboratory assessments;

   iii. Medications; and,

   iv. Treatments associated with sperm and oocyte cryopreservation.

v. Standard fertility preservation procedures does not include the storage of sperm or oocytes.

H. Biomarker companion diagnostic tests designed to direct specific cancer treatments and targeted drug therapies.

I. Sports physicals for Enrollees provided by school based health centers.

J. Any services or settings identified in Appendix E which are offered at the option of the MCO.

K. Any services or settings which are in-lieu-of services or settings covered under the State Plan, provided they meet the terms outlined in Appendix R of this Agreement.

L. The Collaborative Care Model (CoCM), as outlined below:

i. The CoCM incorporates a team of three providers: a primary care provider, a behavioral health care manager, and a psychiatric consultant.

ii. CoCM sites may target individuals diagnosed with mild to moderate depression using Patient Health Questionnaire-9 (PHQ-9) screening tool or may specify a different target population with a behavioral health need (either substance use disorder or mental health).

2. To comply with requirements governing emergency and post-stabilization services under 42 CFR 438.114.

3. To comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions, that are set forth in 42 CFR 434.6(a)(12) and 42 CFR 447.26, and to report all identified provider-preventable conditions in a form or frequency specified by MDH.

E. **Quality Improvement**

1. To implement an ongoing comprehensive quality assessment and performance improvement program for the services furnished to its Enrollees that includes, but is not limited to:

A. Performance improvement projects in accordance with 42 CFR 438.330(d);

B. Collection and submission of performance measurement data in accordance with 42 CFR 438.330 (c);

C. Mechanisms to detect underutilization and overutilization of services; and

D. Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2. To participate in annual Quality Meetings with MDH to evaluate MCO performance and operations.

3. To participate in all quality improvement activities listed in COMAR 10.67.04.03B (Appendix S).

4. To participate in annual validation and evaluation of MCO provider networks.

5. To comply with MDH's Network Adequacy Standards and cooperate with all activities led by MDH or the external quality review organization (EQRO) to validate compliance with the Network Adequacy Standards (Appendix F).

6. To maintain NCQA accreditation, as set forth in 42 CFR §438.332(b) and COMAR 10.67.03.08 (Appendix S), and to provide MDH a copy of its most recent NCQA accreditation results when available, including:

   A. Accreditation status, survey type, and level;

   B. Accreditation results, including:

      i. Recommended actions or improvements,

      ii. Corrective action plans, and

      iii. Summaries of findings; and

   C. Expiration date of accreditation.

7. To obtain NCQA Health Equity Accreditation by December 31, 2025.

8. To provide to MDH a readiness assessment and work plan for efforts to achieve or maintain NCQA Health Equity Accreditation, along with the Culturally and Linguistically Appropriate Services program description to support MCO health equity efforts, upon request.

9. To cooperate with any corrective actions and intermediate sanctions arising from MDH's Performance Monitoring Policies (Appendix D) and HealthChoice Encounter Data Quality Policy (Appendix O).

F. **Service Authorization and Utilization Management**

1. To place appropriate limits on services for utilization control, provided that:

   A. The services furnished can reasonably achieve the purpose for which the services are provided;

   B. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and

   C. Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used.

2. To adopt, apply, review, and update any practice guidelines in accordance with the requirements of COMAR 10.67.03.09L (Appendix S) and 42 CFR 438.236, and to disseminate practice guidelines to all affected providers.

3. To have in place, and follow (along with its contractors), written policies and procedures for the processing of requests for initial and continuing authorizations of services and have mechanisms to ensure consistent application of review criteria for authorization decisions, including consultations with specialists, as appropriate.

4. To adhere to the requirements for service authorization and notification set forth in 42 CFR 438.210(d) and COMAR 10.67.09.04 (Appendix S).

5. Pursuant to 42 CFR 438.3(i) and 422.208, not to make payment directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual Enrollee.

6. To cover gender-affirming treatment when the treatment is:

   A. Prescribed to an Enrollee because of, related to, or consistent with the Enrollee’s gender identity;

   B. Medically necessary; and

   C. Prescribed in accordance with current clinical standards of care.

7. To issue an adverse benefit determination denying or limiting access to gender-affirming treatment only if a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

8. To execute an agreement with MDH's Independent Review Organization vendor and comply with the standards set forth in COMAR 10.67.13 (Appendix S).

G. **Coordination of Care**

1. To coordinate care and deliver quality health care to the MCO's Enrollees by providing all necessary information to the Medicaid Program, its authorized agents, the Administrative Services Organizations with which MDH contracts and to any other entity as directed by MDH, in accordance with applicable federal and state confidentiality laws and regulations.

2. For Enrollees with behavioral health conditions, coordination of care should include but not be limited to:

   A. Participation in monthly collective MCO medical directors' meetings and one-on-one MCO meetings with the ASO for care coordination,

   B. Cooperation with MDH's high utilizer pilot program,

   C. Assistance with the development and coordination of appropriate treatment plans for Enrollees,

   D. Provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process,

   E. Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and

   F. Provider education for Enrollee identification and referrals to the ASO or core service agencies for behavioral health services,

3. To implement procedures to deliver care to and coordinate services for all Enrollees. These procedures must do the following:

   A. Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee (e.g., a primary care provider);

   B. Provide the Enrollee with information on how to contact their designated person or entity;

   C. Coordinate the services the MCO furnishes to the Enrollee:

      i. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

ii. With the services the Enrollee receives from any other MCO;

iii. With the services the Enrollee receives in FFS Medicaid; and

iv. With the services the Enrollee receives from community and social support providers.

D. Make a best effort to conduct an initial screening of each Enrollee's needs, within 90 days of the effective date of enrollment for all new Enrollees, including subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful;

E. Share with MDH or other MCOs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of services or benefits;

F. Use CRISP to identify new Enrollees and their potential risk categories and to coordinate with other MCOs as appropriate for transition of care activities;

G. Ensure that each provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards;

H. Ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable; and

I. Agree to collaborate with MDH to develop a coordinated social determinants of health referral strategy, including ensuring that a screening tool is completed for each Enrollee to assess social determinants of health that may impact the Enrollee's health needs.

H. **Information Requirements**

1. To comply with all marketing requirements under 42 CFR 438.104 and COMAR 10.67.04.23 (Appendix S).

2. To comply with the rules, language, and format standards for Enrollee information set forth in 42 CFR 438.10(c) and (d) and COMAR 10.67.05.01 (Appendix S).

3. To provide Enrollees with an Enrollee handbook using the model template developed by MDH, and ensure it contains the minimum requirements outlined in 42 CFR 438.10(g)(2) and COMAR 10.67.05.02 (Appendix S).

4. To provide Enrollees with a network provider directory and ensure it contains the minimum information about physicians (including specialists), hospitals, and pharmacies outlined in 42 CFR 438.10(h)(1) and COMAR 10.67.05.02 (Appendix S).

5. To submit changes to Enrollee handbooks and Enrollee notices to MDH for review and approval prior to use and dissemination.

I. **Reporting Requirements**

1. To prepare and submit to MDH HealthChoice Financial Monitoring Reports in accordance with the following schedule:

   A. For services incurred January 1 – December 31 of the prior year, reported through March 31 of the current year, the MCO shall submit its HealthChoice Financial Monitoring report no later than May 15 of the current year.

   B. For services incurred January 1 – December 31 of the prior year, reported through June 30 of the current year, the MCO shall submit its HealthChoice Financial Monitoring report no later than September 1 of the current year.

2. To submit to MDH the reports described in COMAR 10.67.07.03 (Appendix S).

3. To seek and obtain MDH's approval before making or allowing any material deviations in corporate structure, management, or operations from the MCO application and supporting documentation that was provided and approved pursuant to COMAR 10.67.03 (Appendix S).

4. To maintain a health information system that collects, analyzes, integrates, and reports data, including encounter data and that can achieve the objectives of 42 CFR 438, subpart D; and to comply with the requirements of 42 CFR 438.242(b) and (c) and COMAR 10.67.04.15 (Appendix S).

5. To submit encounter data that identifies the provider who delivers any items or services to enrollees at a frequency and level of detail to be specified by CMS and MDH, including, at a minimum:

   A. Enrollee and provider identifying information;

   B. Service, procedure, and diagnoses codes;

   C. Allowed, paid, enrollee responsibility, and third-party liability amounts; and

   D. Service, claims submission, adjudication, and payment dates.

6. To identify sub-capitated arrangements and denied claims in the 837 encounter data submissions (refer to the MDH 837 Encounter Companion Guides for the appropriate CN1 segment and data elements).

7. To submit to MDH a list of all State fair hearings held, and decisions rendered during the preceding quarter, within 10 calendar days after the close of each calendar quarter, in the format specified by MDH.

8. To transfer historical utilization data upon request for any members who have disenrolled from the MCO in the timeframe and format specified by MDH.

9. To submit information to MDH for a report that is due to CMS on or before October 1, 2024, and provide other information as needed to ensure ongoing compliance with 42 CFR 438, subpart K (applying parity standards from the Mental Health Parity and Addiction Equity Act), including engaging in the following:

   A. Purchasing a license for and utilizing the URAC Parity Manager Tool;

   B. Providing comprehensive responses and completing all requested fields in the URAC Parity Manager Tool and updating information on an annual basis; and

   C. Responding to all follow-up requests by MDH for additional information; and

   D. Generating and submitting reports as required by MDH to monitor the impact of non-quantitative limits in operation which may include denial rates, prior authorization rates, utilization trends, and results of interrater reliability surveys.

10. To supply other information requested by MDH, given a reasonable period of notice, for the purposes of Maryland Medicaid Managed Care Program administration or MDH's monitoring of MCO performance pursuant to 42 CFR 438.66 and COMAR 10.67.04.15 (Appendix S).

11. To report third-party liability collection activities as described in 10.67.04.18 (Appendix S).

J. **Financial Requirements**

1. To calculate and report a medical loss ratio for each rating year to MDH in the form and manner specified in 42 CFR 438.8 and §II.K of this Agreement.

2. To accept the capitation rates set forth in Appendix C (Managed Care Organization Service Areas and Reimbursement Rates) as payment for services rendered to Enrollees of the Maryland HealthChoice Program.

3. To participate in the Population Health Incentive Program (PHIP) outlined in Appendix N of this Agreement, the funding level for which is 0.5% of the HealthChoice total capitation for the measurement year.

4. To participate in MDH's stop-loss program in accordance with COMAR 10.67.04.22 (Appendix S) and to accept a stop-loss limit of $150,000 per Enrollee.

5. To acknowledge the standards governing the Program's Health Equity Incentive as outlined in Appendix O, and to accept incentive payments developed in accordance with the methodology and 42 CFR 438.6 for the one-year rating period covered by this Agreement, subject to approval by MDH.

6. To continue to reimburse COVID administration ingredient and vaccination costs outside of capitation rates through a reconciliation process until 100% federal funding is no longer available (currently available through September 30, 2024).

7. To accept as payment in full the amounts paid by MDH pursuant to Appendix C, and not to seek or accept additional payment from any Enrollee for any covered service; provided, however, that nothing in this Agreement shall prevent the MCO from seeking coordination of benefits or subrogation recoveries in accordance with applicable rules and regulations.

8. To refrain from making any expenditure for organ transplants, except as provided for in the State Plan and Section 1903(i) of the Social Security Act.

9. Except as provided in Section 1903(i) of the Social Security Act, to refrain from paying for any item or service furnished by any individual or entity to whom the State has failed to suspend payments under the State Plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with federal regulations, unless the State determines in accordance with such regulations there is good cause not to suspend such payment.

10. To refrain from making any expenditure with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or with any respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan and Section 1903(i) of the Social Security

Act, except as provided for in Section 1903(i) of the Social Security Act.

11. To refrain from paying for an item or service (other than an emergency item or service) for home health care services provided by an agency or organization, unless the agency provides a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

12. Not to hold Enrollees, MDH, or DHHS liable for the debts of the MCO or any of its subcapitated providers in the event of the MCO's insolvency or the insolvency of its subcapitated provider, but nothing in this paragraph shall waive the MCO's right to be paid for the services that it has provided to its members.

13. Not to hold Enrollees or DHHS liable for the debts of the MCO for services provided to the Enrollee:

    A. If the MCO fails to receive payment from MDH for such services, or

    B. If a health care provider with a contractual, referral, or other arrangement with the MCO fails to receive payment from MDH or the MCO for such services.

14. To make payment to health care providers for items and services which are subject to this Agreement and that are furnished to the Enrollees on a timely basis consistent with the claims payment procedures described in section §1902(a)(37)(A) of the Social Security Act, 42 CFR 447.46 and the applicable provisions of 42 CFR 447.45, Maryland Annotated Code, Insurance Article, §15-1005 and Health-General Article, §15-102.3 unless the health care provider and the MCO agree to an alternate payment schedule.

15. To make pass-through payments to the Maryland Trauma Physician Services Fund, as set forth in Health General Article § 19-130(b)(2), Maryland Annotated Code.

16. To reimburse Maryland hospital providers based on rates approved by the HSCRC.

17. To reimburse network providers for evaluation and management (E&M) codes at the Maryland Medicaid Fee-for-Service rates, at a minimum.

18. To reimburse self-referred services at the Maryland Medicaid Fee-for-Service rates, at a minimum.

19. To reimburse providers for CoCM services at the Medicare rate, at a minimum.

20. To acknowledge and adhere to the HealthChoice Financial Sanction Policy, as outlined in Appendix I.

21. To participate in the Maryland Quality Incentive Program as described in Appendix J, contingent upon CMS approval.

22. To reimburse CDC-recognized organizations participating in the HealthChoice Diabetes Prevention Program at a rate equal to or greater than the rates specified in the fee schedule in Appendix K.

23. To comply with requirements established by MDH regarding incentive funding for COVID-19 Public Health Emergency (PHE) Unwinding Communications, and to accept payments developed in accordance with 42 CFR 438.6 for the one-year rating period covered by this Agreement.

K. **Medical Loss Ratio**

1. To provide to MDH a completed MLR Reporting Template, including the MCO attestation and any additional documentation supporting the MLR reporting template (Appendix G), in accordance with 42 CFR 438.8, by September 1 of the calendar year following the MLR reporting year.

2. To provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent.

3. To report fraud prevention activities to MDH as required by 42 CFR 438.8.

4. To recalculate and resubmit the MLR report for all MLR reporting years affected if MDH makes retroactive changes to the capitation payments that impacts the MLR reporting year.

5. To attest to the accuracy of the calculation of the MLR when submitting its report to MDH.

6. To acknowledge the right to appeal a remittance being due to MDH within 30 days of notice, and that filing the appeal does not stay the obligation to remit the amount owed to MDH.

L. **Program Integrity**

1. To implement and require its responsible subcontractors to implement procedures that are designed to detect and prevent fraud, waste, and abuse set forth in 42 CFR 438.608 and COMAR 10.67.07 (Appendix S).

2. To designate a compliance officer, who reports directly to the chief executive officer and the board of directors and is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract, and at minimum the following staff members:

   A. An investigator who is responsible for fraud, waste, and abuse investigations;

   B. An auditor who is responsible for identifying potential fraud, waste, and abuse through analysis of claims and related information; and

   C. An analyst capable of reviewing data and codes who is responsible for reviewing and researching evidence of potential fraud, waste, and abuse.

3. To maintain staffing and resources located in Maryland to identify and investigate potential fraud, waste, and abuse, which shall be based on criteria determined by MDH that may include but are not limited to:

   A. Number of enrollees;

   B. Number of claims received on an annual basis;

   C. Volume of suspected fraudulent and abusive claims currently being detected;

   D. Other factors relating to the vulnerability of the MCO to fraud and abuse; and

   E. An assessment of optimal caseload which can be handled by an investigator on an annual basis.

4. To permit MDH, the Maryland Office of the Inspector General for Health (OIGH), the Maryland Insurance Administration, and/or DHHS, or any of their respective designees, with respect to the MCO and any of its subcontractors, as required by 42 CFR 438.6(h), to:

   A. Evaluate the quality, appropriateness, and timeliness of services performed through inspection, or other means, including accessing the MCO and its subcontractors' facilities using enrollment cards and identities established in the manner specified by MDH; and

   B. Inspect and audit any financial records, including but not limited to reimbursement rates.

5. To inform its subcontractors of the provisions of the Social Security Act §1128 B (Criminal Penalties for Acts Involving Federal Health Care Programs).

6. In accordance with Section 1903(m)(4)(B) of the Social Security Act, to report to the State and, upon request, to the Secretary or the Inspector General of MDH of Health and Human Services, the Comptroller General and Enrollees, a description of transactions between the MCO and a party in interest (as defined in section 1318(b) of The Public Health Service Act, including the following transactions:

   A. Any sale, exchange, or leasing of any property between the MCO and such a party.

   B. Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

   C. Any lending of money or other extension of credit between the MCO and such a party.

7. To comply with 42 CFR 438.610 by not knowingly having as a director, officer, partner, owner of more than five percent (5%) of the MCO's equity, a network provider, or a person with an employment, consulting, or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its Agreement with MDH, who is:

   A. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549;

   B. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph HH(1) above; or

   C. An individual or entity that is excluded from participation in any Federal health care program under sections 1128 or 1128A of the Social Security Act.

8. To acknowledge the sanction provisions under 42 CFR, Part 438, Subpart I, in Health-General Article §15-103(b)(9), and COMAR 10.67.10.01 (Appendix S).

9. To search the DHHS-OIG's List of Excluded Individuals/Entities, the General Services Administration Excluded Parties List System, the Social Security Administration Death Master File, and the National Plan & Provider Enumeration System for individuals excluded from the Medicaid Program. Searches shall be done upon execution of this Agreement, and the LEIE and EPLS shall be checked at least monthly thereafter, using the names of all contracted individuals and entities,

those with an ownership or control interest, and their agents and managing employees, in accordance with 42 CFR 455.436.

10. To create and manage processes to verify by sampling or other methods whether services billed by network providers were received by Enrollees at least quarterly in accordance with 42 CFR 438.608(a)(5), report the findings to OIGH on a quarterly basis, and provide evidence of verification efforts through a report to MDH and OIGH annually.

11. To require MCO program integrity representatives to attend in-person meetings with MDH and report ongoing efforts to detect and prevent fraud, waste, and abuse.

12. To identify and collect monies owing from responsible third parties liable for the cost of medical care furnished by the MCO to Enrollees in accordance with COMAR 10.67.04.18 (Appendix S).

13. To create and manage mechanisms to detect fraud and abuse and report to MOIGH, in accordance with MOIGH protocols.

14. To report excess capitation or other contract overpayments to MDH or its designee within 60 calendar days of discovery, in accordance with 42 CFR 438.608(d).

15. To develop and maintain adequate overpayment identification, collection, and reporting policies and procedures consistent with 42 CFR 438.608(d)(2).

16. To establish edits in the MCO's claims processing system to cross-reference known deceased Enrollees' names and dates of death.

17. To perform activities to ensure payments are not issued for deceased Enrollees, including but not limited to analytical reviews of encounter data looking for indications of payments for services after death, including billing patterns (e.g., multiple types of service pre-death and only one type of service after death or large differences in spending before and after death).

18. To develop written policies and procedures for payment suspensions in cases of credible allegations of fraud that comply with 42 CFR 455.23 and 438.608(a)(8), and provide these policies and procedures to MDH and OIGH upon request.

19. To provide to MDH, monthly in a format directed by MDH, data on recoveries from responsible third parties at the claim level, including but not limited to:

    A. Paid amount;

B. Other insurance billed/paid;

C. Units billed;

D. Provider information, including NPI and Tax ID.

20. To attend and participate in quarterly meetings with the Maryland Office of the Inspector General for Health to discuss fraud, waste, and abuse efforts; training initiatives; and other information to strengthen program integrity.

21. To provide to OIGH paid claims data reporting or other ad hoc data reporting upon request.

22. To recover, through claims submission or other appropriate means, from responsible third-party insurers, including but not limited to commercial carriers, Medicaid, and Medicare, within 18 months from the MCO's claims payment date for the cost of covered services incurred by the MCO on behalf of an enrollee for services that should have been paid through a third party, for the full amount of medical assistance provided.

    A. All recoveries from responsible third-party insurers outside of the 18-month period may be pursued by MDH at MDH's discretion.

    B. Tort cases are excluded from the third-party insurer recovery process identified above.

M. **Subcontractors**

1. To comply with the requirements for the service or activity delegated under the subcontract set forth in 42 CFR 438.230 and COMAR 10.67.04.17 (Appendix S).

2. To ensure all written agreements between the MCO and each of its Subcontractors includes the contractual provisions outlined in COMAR 10.67.04.17A(3)(a)-(n) (Appendix S).

3. To routinely monitor Subcontractor performance and enforce corrective action for poor performance in all areas under the scope of the agreement between the Subcontractor and the MCO, including but not limited to the areas of enrollee and provider complaints, access issues, quality assurance activities, recordkeeping, and reporting requirements.

4. To report to MDH upon learning of any material deviations from required procedures by its Subcontractor which, in the MCO's judgment, can be expected to have a significant effect on plan responsibilities and/or operations, quality of care, or on Enrollees' ability to access care.

5. To structure compensation to Subcontractors conducting utilization management activities so as not to provide incentives for denying, limiting, or discontinuing medically necessary services to any Enrollee, in accordance with 42 CFR 438.210(e).

6. To use MDH's Ownership and Control Disclosure Form to collect ownership and control, business transaction, and criminal conviction information from the MCO's Subcontractors and delegated vendors, and to furnish that information to MDH upon request.

N. **Network Providers**

1. To demonstrate, in accordance with 42 CFR 438.207, COMAR 10.67.03.05, COMAR 10.67.05.05, and COMAR 10.67.05.05-1 (Appendix S) that the MCO:

   A. Offers an appropriate range of preventive, primary care, and specialty services adequate for the anticipated number of Enrollees in the MCO's service areas.

   B. Maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the number of Enrollees in the MCO's service areas.

   C. Ensures that in-plan individual practitioners, based on full-time equivalency, are assigned no more than the number of enrollees that is consistent with a 200:1 ratio of enrollee to practitioner in the local access area.

   D. Meets MDH's Network Adequacy Standards (Appendix F) in each service areas the MCO plans to enter or is enrolled.

   E. Demonstrates to MDH's satisfaction the adequacy of its provider network if it cannot meet the Network Adequacy Standards, by providing evidence and assurances of the overall strength of the MCO's network and that the network will enhance recipients' overall access to quality health care services in the area to be served.

2. To maintain written policies and procedures for selecting and retaining network providers in accordance with the requirements of 42 CFR 438.214 and the applicable provider panel provisions of Maryland Insurance Article § 15-112, Code Ann.

3. To ensure network selection policies and procedures do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, in accordance with 42 CFR 438.214(c).

4. To ensure that all its network providers are screened, enrolled, and revalidated by the State as Medicaid providers, in accordance with 42 CFR part 455, subparts B and E, and validate enrollment by verifying against MDH's full fee-for-service provider file.

5. To require that network providers enroll and comply with the requirements of MDH's Electronic Provider Revalidation Enrollment Portal (ePREP) in accordance with 42 CFR 438, subpart H.

6. To validate that any network provider rendering or receiving payment for covered services is enrolled and active on the date(s) of service by verifying against the full fee-for-service provider enrollment file from MDH.

7. To accept the Maryland Uniform Credentialing Form for the credentialing of network providers.

8. To refrain from discriminating against providers serving high-risk populations or specializing in conditions requiring costly treatment.

9. To inform all providers at the time of entering a contract with the MCO about the grievance and appeal system, as set forth in 42 CFR 438.414 and 42 CFR 438.10(g)(2)(xi).

10. To monitor MDH's correspondence and any database publicizing Department-initiated terminations of providers from the Program.

11. To terminate the contract of, or refrain from contracting with, providers terminated or excluded from participating in the Program.

12. To develop and distribute a provider manual that includes all the information provided in MDH's template and required in COMAR 10.67.05.04A(2).

13. To distribute to network providers the MCO's practice guidelines, as described in 42 CFR 438.236.

14. To ensure services are delivered in a culturally competent manner to all Enrollees, including:

    A. Enrollees with limited English proficiency;

    B. Enrollees with diverse cultural and ethnic backgrounds; and

    C. Enrollees of all genders, sexual orientations, and gender identities.

15. To ensure its provider network can provide physical access, reasonable accommodation, and accessible equipment for Enrollees with physical or mental disabilities.

16. To treat services provided by doulas active and enrolled in Maryland Medicaid as self-referral services for the term identified in this Agreement and through December 31, 2025.

17. To provide and reimburse for necessary services covered under the contract out of network adequately and timely for Enrollees in accordance with 42 CFR 438.206, for as long as the MCO's provider network is unable to provide them under regulatory network adequacy standards as outlined in COMAR 10.67.05.01 *et. seq.* (Appendix S).

18. To establish coverage, requirements, and reimbursement procedures for practices providing CenteringPregnancy services who enroll in Maryland Medicaid to provide services for pregnant and postpartum Enrollees.

19. To establish coverage, requirements, and reimbursement procedures for practices providing HealthySteps services who enroll in Maryland Medicaid to provide services for pediatric Enrollees.

20. To establish coverage, requirements, and reimbursement procedures for the following covered services:

    A. Gender-Affirming Treatment services.

    B. Standard Fertility Preservation Services.

    C. Adult vaccinations.

    D. Biomarker Companion Diagnostic Tests.

    E. Sports physicals, when provided by school based health centers.

O. **MCO Appeal Rights**

1. To acknowledge its right to appeal under the following grounds:

    A. Decision to terminate the MCO's participation in the Maryland Medicaid Managed Care Program;

    B. Decision to impose a fine or other sanction on the MCO as described in COMAR 10.67.10.01;

    C. Order to provide benefits or services to Enrollees;

    D. Order that the MCO is impaired or in "hazardous financial condition;"

    E. An adverse decision by the IRO as described in COMAR 10.67.13.08;

F. The amount of a penalty or incentive as described in COMAR 10.67.04.03;

G. The denial of a hepatitis C payment as described in COMAR 10.67.04.19;

H. Overpayments recovered by MDH;

I. Remittances to MDH related to MLR reporting.

2. To appeal to the Office of Administrative Hearings as specified in COMAR 10.09.36.09 and COMAR 10.01.03 (Appendix S).

3. To acknowledge and agree that the following sanctions take effect immediately and are not subject to stay during the pendency of an appeal:

A. Any fines imposed;

B. Orders to provide a benefit or service to Enrollees;

C. Any full or partial withhold of the capitation payment;

D. Any remittances to MDH related to MLR; or

E. Any overpayments recovered by MDH related to program integrity efforts, as described in COMAR 10.67.07.01.

P. **Pharmacy**

1. To maintain drug review and utilization requirements that comply with 42 USC 1396a (oo), excluding sections (1)(A)(i)(III) and (B), along with the following drug utilization review requirements from 42 CFR 456.703:

A. Prospective safety edit limitations for opioid prescriptions, on days' supply for patients not currently receiving opioid therapy for initial prescription fills; quantity of prescription dispensed for initial and subsequent prescription fills; therapeutically-duplicative initial and subsequent opioid prescription fills; and early refills, for subsequent prescription fills.

B. Prospective safety edit limitations for opioid prescriptions on the maximum daily morphine milligram equivalent for treatment of pain, for initial and subsequent prescription fills.

C. A retrospective claims review automated process that indicates prescription fills of opioids in excess of the prospective safety edit limitations specified in Section II.P.1.A-B to provide for the ongoing review of opioid claims data to identify patterns of fraud, abuse, excessive utilization, inappropriate or medically

unnecessary care, or prescribing or billing practices that indicate abuse or provision of inappropriate or medically unnecessary care among prescribers, pharmacists, and individuals receiving Medicaid benefits.

D. A process to identify potential fraud or abuse of controlled substances by individuals enrolled under the State Plan, health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

E. Retrospective claims review automated processes to identify when an Enrollee is prescribed an opioid after the Enrollee has been prescribed one or more drugs used for medication assisted treatment of an opioid use disorder or has been diagnosed with an opioid use disorder, in the absence of a new indication to support utilization of opioids (such as new cancer diagnosis or hospice care); and an Enrollee could be at high risk of opioid overdose and should be considered for co-prescription or co-dispensing of any FDA-approved opioid antagonist/reversal agent.

2. To cover outpatient drugs as defined in § 1927(k)(2) of the Social Security Act and comply with the requirements outlined in 42 CFR 438.3(s).

3. Pharmacy Benefit Managers (PBMs)

A. To disclose for each pharmaceutical claim the amount the MCO paid the PBM, and of that amount, the amount paid to the pharmacy, including identifying the dispensing fee and the ingredient cost (if applicable), in a format and frequency determined by MDH.

B. To base PBM reimbursement on the actual amount paid by the PBM to a pharmacy for dispensing and ingredient costs.

C. To manage or delegate to the PBM any drug pricing appeals from pharmacies and resolve all appeals within 21 days of receipt of the request to review.

D. To comply with the requirements in Ins. Art. 15-1611.1 and Ins. Art. 15-1628.3.

E. To require PBMs to consider both ingredient costs and dispensing fees when determining reimbursement to pharmacies.

F. To comply with the prohibition of spread pricing reimbursement in PBM contracting.

4. To comply with MDH's opioid drug utilization review policies and its corrective managed care regulations set forth in COMAR 10.67.12 (Appendix S), including but not limited to providing provider education about prescribing limits, applying prior authorization requirements, and submitting reports to MDH upon request.

5. To require the PBM, through amending the contract between the MCO and PBM and the contract between the PBM and pharmacy network, to comply with the following prohibitions, which do not preclude the reprocessing of claims due to claims adjudication errors made by the MCO, PBM, or an agent of either entity:

   A. To prohibit the PBM from collecting direct or indirect remuneration fees, membership fees, or similar fees from pharmacies or other contracted entities acting on behalf of pharmacies as a condition of claims payment or network inclusion.

   B. To prohibit the PBM from implementing retrospective remuneration models, including but not limited to Generic Effective Rates (GERs) and Brand Effective Rates (BERs).

   C. To implement this requirement, PBMs operating on behalf of the MCO must amend all contracts and/or agreements with participating network pharmacies no later than the end of the term of this Agreement to include the following language:

      "Pursuant to contractual requirements of Managed Care Organizations (MCOs) operating within the Maryland HealthChoice Program, any Pharmacy Benefit Manager (PBM) operating on behalf of a Maryland HealthChoice Program MCO is prohibited from collecting direct or indirect remuneration fees, membership fees, or similar fees associated with Maryland HealthChoice claims from network pharmacies or other contracted entities acting on behalf of network pharmacies as a condition of claims payment or network inclusion. Further, PBMs operating on behalf of a Maryland HealthChoice Program MCO are prohibited from implementing retrospective remuneration models for Maryland HealthChoice claims, including but not limited to Generic Effective Rates (GERs) and Brand Effective Rates (BERs). For purposes of this requirement, "direct or indirect remuneration fees" may include but are not limited to a) any pay-to-play for network participation; b) any fees for periodic reimbursement reconciliations to provide a true-up between a target reimbursement rate in a participating pharmacy agreement and the aggregated effective rate actually realized by a pharmacy or between the aggregate maximum allowable cost (MAC) or adjudicated rate and the aggregate contracted rate; or c) any

payment mechanism to pharmacies for the fulfillment of quality measures or fee assessed to pharmacies for noncompliance with quality measures."

6. To comply with MDH's high-cost low volume drug policy (Appendix L-1) and Hepatitis C risk pool reimbursement method (Appendix L-2).

7. To conduct an annual audit to review the performance of the PBM in the following areas, at a minimum:

   A. Claims processing

   B. Payment methodology

   C. Allowable adjustments

8. To require in the PBM contract the hiring of an independent third party to complete an annual Service Organization Controls report (SOC-2, type 2) audit over the PBM's services and activities by the end of the Agreement term.

9. To submit summary reports of the annual audit findings of the audits required under (7) and (8), including any corrective actions that the MCO will mandate of their PBM, in the event issues have been identified by the audit.

10. To submit unredacted agreements between the MCOs and their PBMs to MDH upon request.

11. To require the PBM to submit unredacted pharmacy network agreements; including contracts, rate sheets, and provider manuals; between the PBMs and their Pharmacy providers to MDH upon request.

12. To disclose to MDH the supplemental rebates allocation methodology between the PBM and the MCO.

13. To disclose to MDH all supplemental rebate revenue from the PBM on the HealthChoice Financial Monitoring Report.

14. To continue monthly reconciliation activities with MDH's Point-Of-Sale vendor for all paid claims processed by the MCO and its respective PBM to ensure all claims are processed through the Coordinated Prospective Drug Utilization Review. The MCO and its respective PBM shall support this process by:

   A. Sending and receiving files as required,

   B. Attending all meetings for reconciliation, and

C. Working with MDH and its point-of-sale vendor to ensure all discrepancies are resolved and received as directed by MDH.

15. To exclude drugs for treatment of diabetes, HIV, or AIDS from being classified as specialty drugs, in accordance with Md. Health-General Code Ann. § 15-118.1.

16. To eliminate prior authorization requirements for postexposure prophylaxis for the prevention of HIV if prescribed for use in accordance with Centers for Disease Control and Prevention guidelines, in accordance with Md. Code Ann. Ins. Art. 15-858.

17. To provide coverage and reimbursement for all services rendered by a licensed pharmacist within the pharmacist's lawful scope of practice, as required by Maryland Senate Bill 678, Reimbursement for Services Rendered by a Pharmacist Act (Ch. 300 of the Acts of 2023).

18. To suspend waiver of pharmacy copays to comply with the Mental Health Parity and Addiction Equity Act, effective May 1, 2024, and charge no more than the following amounts:

    A. $3.00 per prescription on new and refill non-preferred drugs;

    B. $1.00 per prescription on new or refill preferred drugs, generic drugs, and HIV/AIDS drugs.

19. To exclude family planning drugs from pharmacy copay requirements.

20. To exclude the following populations from pharmacy copay requirements:

    A. Individuals under the age of 21;

    B. Individuals receiving hospice care;

    C. Pregnant individuals; and

    D. American Indians.

21. To comply with the requirement of section 11405 of the Inflation Reduction Act (IRA), as it relates to coverage and payment for approved adult vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration without Enrollee cost sharing.

III. **MDH AGREES:**

A. **General Requirements**

1. To pay the MCO in accordance with COMAR and Appendix C, which may be amended throughout the term of the Agreement.

2. To develop capitation rates that are:

   A. Actuarially sound to allow the MCO to effectively deliver covered services to Enrollees in a manner compliant with the requirements of this Agreement and 42 CFR 438.4 through 438.7, and 438.602(i); and

   B. Based only upon services covered under the State Plan and additional services deemed by the State to be necessary to comply with the requirements of 42 CFR 438, subpart K of this part (applying parity standards from the Mental Health Parity and Addiction Equity Act).

3. To develop PHIP and Health Equity incentive payments in accordance with the standards set forth in 42 CFR 438.6(b)(1).

4. To develop stop-loss insurance in accordance with the standards set forth in 42 CFR 438.4 and 438.5.

5. To produce and make available to the MCO monthly a remittance advice and the following reports:

   A. MCO Capitation Detail Report;

   B. MCO Capitation Summary Report;

   C. MCO Capitation Report by Rate Group;

   D. MCO Capitated Enrollment Report;

   E. MCO Capitated Enrollment Summary;

   F. MCO Disenrollment Report by Site;

   G. MCO Capitated Disenrollment Summary;

   H. Zip Code Totals within MCO by Provider;

   I. MCO Eligibility and Enrollment Renewal Files; and

   J. Enrollee Bad Address File.

6. To include in the monthly enrollment listings sent to the MCO the adjustments provided by the MCO and accepted by MDH, and other appropriate debit and credit transactions.

7. To provide to the MCO at least 15 days' notice of any policy changes.

8. To make the accreditation status for the MCO available on the Website as required under 42 CFR 438.10(c)(3), including whether the MCO has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually.

B. **Monitoring Requirements**

1. To review the ownership and control disclosures submitted by the MCO and those of any of the MCO's subcontractors, upon request.

2. To collect (including through its agents and contractors) the following information from the MCO to improve the performance of the managed care program, including at a minimum:

   A. Enrollment and disenrollment trends in the MCO;

   B. Member grievance and appeal logs;

   C. Provider complaint and appeal logs;

   D. Findings from the State's External Quality Review process;

   E. Results from any Enrollee or provider satisfaction survey conducted by the State or MCO;

   F. Performance on required quality measures;

   G. Medical management committee reports and minutes;

   H. The annual quality improvement plan for the MCO;

   I. Audited financial and encounter data submitted by the MCO;

   J. Network adequacy assurances submitted by the MCO;

   K. The medical loss ratio summary reports required by 42 CFR 438.8; and

   L. Customer service performance data submitted by the MCO and performance data submitted by the beneficiary support system.

C. **Prevalent Non-English Languages**

1. To specify that, at the time of this Agreement, the prevalent non-English languages spoken by Enrollees and potential Enrollees in the State are as follows:

   A. Amharic

   B. Arabic

   C. Bassa

D. Chinese

E. Farsi

F. French

G. Gujarati

H. Haitian Creole

I. Igbo

J. Korean

K. Portuguese

L. Russian

M. Spanish

N. Tagalog

O. Urdu

P. Vietnamese

Q. Yoruba

D. **Imposition of Sanctions**

1. To give the MCO timely written notice explaining the basis and nature of any sanctions imposed, in accordance with COMAR 10.67.10.01A (Appendix S). Sanctions may include, but are not limited to:

   A. Fines;

   B. Suspension of further enrollment;

   C. Withholding all or part of the capitation payment;

   D. Termination of the Agreement;

   E. Disqualification from future participation in the Maryland Medicaid Managed Care Program; and

   F. Those actions outlined in 42 CFR 438.700–438.708, as amended.

2. To provide the MCO notice of appeal rights under COMAR 10.67.10.02 (Appendix S).

3. To permit the MCO the opportunity to take corrective action in accordance with COMAR 10.67.10.01B (Appendix S), through a plan approved by MDH.

IV. MDH AND THE MCO MUTUALLY AGREE:

A. **Agreement Term and Grounds for Termination**

1. That the term of this Agreement shall begin on January 1, 2024, and terminate on December 31, 2024.

2. That the MCO shall provide written notification to MDH of the MCO's intent to terminate this agreement for any future calendar year by October 1 of the prior year according to COMAR 10.67.04.26 (Appendix S).

3. That MDH reserves the right to terminate this Agreement upon:

   A. Completion or termination of the Section 1115 Research and Demonstration Waiver and Federal funding thereunder;

   B. Notification by the Maryland Department of Budget and Management that State funds are not available for the continuation of the HealthChoice Program;

   C. Determination that the MCO or any agent or employee of the MCO, or any person with an ownership interest in the MCO, or a related party of the MCO, has failed to comply with any applicable law, regulation, or Agreement term, or for other good cause shown, pursuant to COMAR 10.67.10 (Appendix S); or

   D. Determination by MDH of insufficient MCO participation in the HealthChoice Program.

4. That if MDH terminates this Agreement for any reason, it shall not be liable for any costs of the MCO associated with the termination, including but not limited to, any expenditures made by the MCO prior to the termination or related to implementing the termination.

5. That termination of this Agreement shall not discharge the obligations of the MCO with respect to services or items furnished prior to termination, including payment for covered services delivered during the Agreement period, retention of records and restitution to MDH of overpayments.

6. That in the event of the termination of this Agreement either by MDH or by the MCO, the MCO will furnish to MDH all information relating to the reimbursement of any outstanding claims for services rendered to its Enrollees, including those of its subcontractors, within forty-five (45) days of the effective date of termination.

7. That prior to termination of this Agreement by MDH, MDH shall provide a pre-termination hearing in accordance with 42 CFR 438.710(b).

B. **Payment**

1. That there will be an acuity adjustment during the mid-year rate evaluation and update in CY 2024 as described in Appendix C.

2. That, except for new Enrollees during the period between ten days after MDH's enrollment agent has notified the MCO of a new enrollment and receipt by the MCO of MDH's next regular monthly payment of capitation payment rates, the MCO is not required to pay for or provide services for any Enrollee for which it has not received a prepaid capitation rate from MDH.

3. That payments made under this Agreement will be denied for new Enrollees enrolled after imposition of such sanction as authorized by 42 CFR §438.702(a)(5):

   A. When MDH determines that the MCO has acted or failed to act as described in 42 CFR §438.700(b)-(d); and
   B. Until CMS or MDH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

C. **Miscellaneous**

1. That the MCO and MDH shall enter into a data use agreement with University of Maryland, Baltimore County acting through its Hilltop Institute, to facilitate the secure transmission of data to MDH's data warehouse.

2. That this Agreement may be modified only in writing by the parties.

3. That this Agreement shall not be transferable or assignable.

4. That any change in Federal or State law or regulation that affects any provision or term of this Agreement shall automatically become a provision or term of this Agreement.

5. That they shall carry out their mutual obligations as herein provided in a manner prescribed by law and in accordance with all applicable regulations and policies as may from time to time be promulgated by DHHS or any other appropriate Federal or State agency, including compliance with the Agreement provisions or conditions required in all procurement contracts and subcontracts as specified under 45 CFR Part 74.

6. That should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of the program authority.

A. MDH must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

B. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work.

C. If MDH paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement, the work was to be performed after the date the legal authority ended, the payment for that work must be returned to MDH.

D. However, if the MCO worked on a program prior to the date legal authority ended for that program or activity, and MDH included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

7. That a notice required to be given to the other party under this Agreement, unless specified otherwise, is effective only if the notice is provided in writing and sent by first-class mail, courier or delivery service, or electronic transmittal of original documents with signatures, to the representative and address for that party listed below:

A. Notices to MDH shall be sent to:

Monchel Pridget
Deputy Director, Managed Care
Maryland Department of Health
201 W. Preston Street, Room 214A
Baltimore, MD 21201
monchel.pridget@maryland.gov

B. Notices to the MCO shall be sent to:

_____
_____
_____
_____
_____

IN WITNESS WHEREOF, the parties hereto have hereunder executed this Agreement the day and year first above written.

FOR MDH:

_____	_____
Date	Ryan B. Moran Deputy Secretary, Health Care Financing Medicaid Director Maryland Department of Health

FOR THE MCO:

_____	_____
Date	Signature
	_____
	_____

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

_____	_____
Assistant Attorney General	Date

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is made by and between the Office of Health Care Financing, a unit of the Maryland Department of Health (MDH) (herein referred to as "Covered Entity") and _____ (hereinafter known as "Business Associate"). Covered Entity and Business Associate shall collectively be known herein as the "Parties."

WHEREAS, Covered Entity has a business relationship with Business Associate that is memorialized in a separate agreement (the "Underlying Agreement") pursuant to which Business Associate may be considered a "business associate" of Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 including all pertinent privacy regulations (45 C.F.R. Parts 160 and 164) and security regulations (45 C.F.R. Parts 160, 162, and 164), as amended from time to time, issued by the U.S. Department of Health and Human Services as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5), and the HIPAA Omnibus Final Rule of 2013 (collectively, "HIPAA"); and

WHEREAS, the nature of the contractual relationship between Covered Entity and Business Associate may involve the exchange of Protected Health Information ("PHI") as that term is defined under HIPAA; and

WHEREAS, for good and lawful consideration as set forth in the Underlying Agreement, Covered Entity and Business Associate enter into this Agreement for the purpose of ensuring compliance with the requirements of HIPAA and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq.*) ("MCMRA"); and

WHEREAS, this Agreement supersedes and replaces any and all Business Associate Agreements the Covered Entity and Business Associate may have entered into prior to the date hereof;

NOW THEREFORE, the premises having been considered and with acknowledgment of the mutual promises and of other good and valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

I. DEFINITIONS

A. Catch-all definition. The following terms used in this Agreement, whether capitalized or not, shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

B. Specific definitions:

1. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 C.F.R. § 160.103, and in reference to the party to this Agreement, shall mean _____, the managed care organization (MCO).

2. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 C.F.R. § 160.103, and in reference to the party to this Agreement shall mean the Maryland Department of Health.

3. HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.

4. Protected Health Information ("PHI"). Protected Health Information or "PHI" shall generally have the same meaning as the term "protected health information" at 45 C.F.R. § 160.103.

II. PERMITTED USES AND DISCLOSURES OF PHI BY BUSINESS ASSOCIATE

A. Business Associate may only use or disclose PHI as necessary to perform the services set forth in the Underlying Agreement or as required by law.

B. Business Associate agrees to make uses and disclosures and requests for PHI consistent with Covered Entity's policies and procedures regarding minimum necessary use of PHI.

C. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity.

D. Business Associate may, if directed to do so in writing by Covered Entity, create a limited data set as defined at 45 C.F.R. § 164.514(e)(2), for use in public health, research, or health care operations. Any such limited data sets shall omit any of the identifying information listed in 45 C.F.R. § 164.514(e)(2). Business Associate will enter into a valid, HIPAA-compliant Data Use Agreement as described in 45 C.F.R. § 164.514(e)(4), with the limited data set recipient. Business Associate will report any material breach or violation of the data use agreement to Covered Entity immediately after it becomes aware of any such material breach or violation.

E. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration or legal responsibilities of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

F. The Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an individual pursuant to §§ 13405(d)(1) and (2) of the HITECH Act. This prohibition does not apply to the State's payment of Business Associate for its performance pursuant to the Underlying Agreement.

G. The Business Associate shall comply with the limitations on marketing and fundraising communications provided in § 13406 of the HITECH Act in connection with any PHI of individuals.

III. DUTIES OF BUSINESS ASSOCIATE RELATIVE TO PHI

A. Business Associate agrees that it will not use or disclose PHI other than as permitted or required by the Agreement, the Underlying Agreement, the MCMRA, as Required by Law, or as authorized by Covered Entity, so long as the authorized use or disclosure is permitted by law.

B. Business Associate agrees to use appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.

C. Business Associate agrees to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement.

D. Reporting Requirements.

1. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including Breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware without unreasonable delay and in no case later than fifteen (15) calendar days after the use or disclosure.

2. If the use or disclosure amounts to a breach of unsecured PHI, the Business Associate shall ensure its report:

A. Is made to Covered Entity without unreasonable delay and in no case later than fifteen (15) calendar days after the incident constituting the Breach is first known, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this Section III.D.1, Business Associate must notify Covered Entity of an incident involving the acquisition, access, use or disclosure of PHI in a manner not

permitted under 45 C.F.R. Part E within fifteen (15) calendar days after an incident even if Business Associate has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA;

B. Includes the names of the Individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach;

C. Is in substantially the same form as Exhibit A hereto.

E. In addition to its obligations in Sections III. A-D, within 30 calendar days after the incident constituting the Breach is first known, Business Associate shall provide to Covered Entity a draft letter for the Covered Entity to review and approve for use in notifying the Individuals that their Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach that includes, to the extent possible:

1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

2. A description of the types of Unsecured PHI that were involved in the Breach (such as full name, Social Security number, date of birth, home address, account number, disability code, or other types of information that were involved);

3. Any steps the affected Individuals should take to protect themselves from potential harm resulting from the Breach;

4. A brief description of what the Business Associate is doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches; and

5. Contact procedures for the affected Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address.

F. In the event the Breach occurs through the fault of Business Associate, Business Associate shall be responsible for notifying Individuals by sending via First Class U.S. Mail the approved letter described in Section III(E) no later than 60 calendar days after discovery of the Breach.

G. In the event the Breach occurs through the fault of Covered Entity, Covered Entity shall be responsible for notifying Individuals no later than 60 calendar days after Covered Entity receives notice of the Breach from the Business Associate.

H. To the extent permitted by the Underlying Agreement, Business Associate may use agents and subcontractors. In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), Business Associate shall ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information, Business Associate must enter into Business Associate Agreements with subcontractors as required by HIPAA;

I. Business Associate agrees it will make available PHI in a designated record set to the Covered Entity, or, as directed by the Covered Entity, to an individual, as necessary to satisfy Covered Entity's obligations under 45 C.F.R.§ 164.524, including, if requested, a copy in electronic format;

J. Business Associate agrees it will make any amendment(s) to PHI in a designated record set as directed or agreed to by the Covered Entity pursuant to 45 C.F.R. § 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.526;

K. Business Associate agrees to maintain and make available the information required to provide an accounting of disclosures to the Covered Entity or, as directed by the Covered Entity, to an individual, as necessary to satisfy Covered Entity's obligations under 45 C.F.R.§ 164.528;

L. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate will comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s);

M. Business Associate agrees to make its internal practices, books, and records, including PHI, available to the Covered Entity and/or the Secretary of HHS for purposes of determining compliance with the HIPAA Rules.

N. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

IV. TERM AND TERMINATION

A. Term. The Term of this Agreement shall be effective as of the effective date of the HealthChoice Managed Care Organization Agreement, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or the PHI created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, in accordance with the termination provisions in this Section IV, or on the date the Covered Entity terminates for

cause as authorized in paragraph (b) of this Section, whichever is sooner. If it is impossible to return or destroy all the PHI provided by Covered Entity to Business Associate, or the PHI created or received by Business Associate on behalf of Covered Entity, Business Associate's obligations under this contract shall be ongoing with respect to that information, unless and until a separate written agreement regarding that information is entered into with Covered Entity.

B. Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate, Covered Entity shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement; or

2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and Covered Entity determines or reasonably believes that cure is not possible.

C. Effect of Termination.

1. Upon termination of this Agreement, for any reason, Business Associate shall return or, if agreed to by Covered Entity, destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that the Business Associate still maintains in any form. Business Associate shall retain no copies of the PHI. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

2. Should Business Associate make an intentional or grossly negligent Breach of PHI in violation of this Agreement or HIPAA or an intentional or grossly negligent disclosure of information protected by the MCMRA, Covered Entity shall have the right to immediately terminate any contract, other than this Agreement, then in force between the Parties, including the Underlying Agreement.

D. Survival. The obligations of Business Associate under this Section shall survive the termination of this agreement.

V. CONSIDERATION

Business Associate recognizes that the promises it has made in this Agreement shall, henceforth, be detrimentally relied upon by Covered Entity in choosing to continue or commence a business relationship with Business Associate.

VI. REMEDIES IN EVENT OF BREACH OF AGREEMENT

Business Associate hereby recognizes that irreparable harm will result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associate of any of the covenants and assurances contained in this Agreement. As such, in the event of breach of any of the covenants and assurances contained in Sections II or III above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of Sections II or III. Furthermore, in the event of breach of Sections II or III by Business Associate, Covered Entity is entitled to reimbursement and indemnification from Business Associate for Covered Entity's reasonable attorneys' fees and expenses and costs that were reasonably incurred as a proximate result of Business Associate's breach. The remedies contained in this Section VI shall be in addition to, not in lieu of, any action for damages and/or any other remedy Covered Entity may have for breach of any part of this Agreement or the Underlying Agreement or which may be available to Covered Entity at law or in equity.

VII. MODIFICATION; AMENDMENT

This Agreement may only be modified or amended through a writing signed by the Parties and, thus, no oral modification or amendment hereof shall be permitted. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA rules and any other applicable law.

VIII. INTERPRETATION OF THIS AGREEMENT IN RELATION TO OTHER AGREEMENTS BETWEEN THE PARTIES

Should there be any conflict between the language of this Agreement and any other contract entered into between the Parties (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

IX. COMPLIANCE WITH STATE LAW

The Business Associate acknowledges that by accepting the PHI from Covered Entity, it becomes a holder of medical information under the MCMRA and is subject to the provisions of that law. If the HIPAA Privacy or Security Rules and the MCMRA conflict regarding the degree of protection provided for PHI, Business Associate shall comply with the more restrictive protection requirement.

X. MISCELLANEOUS

A. Ambiguity. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules.

B. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

C. Agency. The Business Associate or Subcontractor is acting as an independent contractor and not as the agent of the Covered Entity or Business Associate. This Agreement does not give the Covered Entity or Business Associate such control over operational activities so as to make the Business Associate the agent of the Covered Entity, or the Subcontractor the agent of the Business Associate.

D. No Private Cause of Action. This Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Agreement, as a result of any claim arising out of the Breach of this Agreement, the HIPAA Standards, or other state or federal law or regulation relating to privacy or confidentiality.

E. Notice to Covered Entity. Any notice required under this Agreement to be given to Covered Entity shall be made in writing to:

Danielle Owens
Privacy Officer
Maryland Department of Health
Office of Internal Controls and Audit Compliance
201 W. Preston Street, Floor 5
Baltimore, MD 21201-2301
Phone: (410) 767-5411
danielle.owens1@maryland.gov

F. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to:

Address: _____

_____

Attention: _____

Phone: _____

G. Survival. Any provision of this Agreement which contemplates performance or observance subsequent to any termination or expiration of this contract shall survive termination or expiration of this Agreement and continue in full force and effect.

H. Severability. If any term contained in this Agreement is held or finally determined to be invalid, illegal, or unenforceable in any respect, in whole or in part, such term shall be severed from this Agreement, and the remaining terms contained

herein shall continue in full force and effect, and shall in no way be affected, prejudiced, or disturbed thereby.

I. Terms. All the terms of this Agreement are contractual and not merely recitals and none may be amended or modified except by a writing executed by all parties hereto.

J. Priority. This Agreement supersedes and renders null and void any and all prior written or oral undertakings or agreements between the parties regarding the subject matter hereof.

IN WITNESS WHEREOF and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

COVERED ENTITY:	**BUSINESS ASSOCIATE:**
By: _____	By: _____
Name: Ryan B. Moran	Name: _____
Title: Deputy Secretary of Health Care Financing and Medicaid Director	Title: _____
Date: _____	Date: _____

EXHIBIT A

FORM OF NOTIFICATION TO COVERED ENTITY OF BREACH OF UNSECURED PHI

This notification is made pursuant to Section III.2.D(3) of the Business Associate Agreement between the Maryland Department of Health (MDH), and _____ (Business Associate).

Business Associate hereby notifies MDH that there has been a breach of unsecured (unencrypted) protected health information (PHI) that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: _____

_____

Date of the breach: _____

Date of discovery of the breach: _____

Does the breach involve 500 or more individuals? Yes/No

If yes, do the people live in multiple states? Yes/No

Number of individuals affected by the breach: _____

Names of individuals affected by the breach: (attach list)

The types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code):

_____

Description of what Business Associate is doing to investigate the breach, to mitigate losses, and to protect against any further breaches:

_____

_____

_____

Contact information to ask questions or learn additional information:

Name: _____

Title: _____

Address: _____

Email Address: _____

Phone Number: _____

AGREEMENT TO PAY FQHCs FOR OUT-OF-NETWORK EMERGENCY SERVICES

I. PAYMENT REQUIREMENTS

A. Effective October 1, 2010, an MCO shall reimburse an out-of-network federally qualified health center (FQHC) for services provided to an Enrollee that are immediately required due to an unforeseen illness, injury, or condition if:

1. The FQHC participates in the Medical Assistance Program;

2. The FQHC does not have a contract with the MCO;

3. The services are immediately required due to the Enrollee's unforeseen illness, injury, or condition;

4. The emergent services are provided on site at the FQHC; and

5. The FQHC has, before rendering services, verified with the Enrollee's primary care provider that the Enrollee cannot be seen within a reasonable amount of time based on the severity of the Enrollee's condition.

B. An MCO may require that the FQHC provide documentation that the FQHC has obtained the verification required under A(5) of this agreement. An MCO is not required to reimburse an out-of-network FQHC for emergent services provided to an Enrollee if the FQHC fails to provide the documentation.

C. An MCO may require that the FQHC provide documentation that services were required for the reasons identified under A (3) of this agreement. An MCO is not required to reimburse an out-of-network FQHC for emergent services provided to an Enrollee if the FQHC fails to provide the documentation.

D. The rate at which the MCO shall reimburse an out-of-network FQHC for services provided under A of this agreement shall be the rate identified in COMAR 10.67.04.21.

E. For any reimbursement paid by an MCO under A of this agreement, the Program shall pay the MCO the difference between the rates identified in COMAR 10.67.04.21 and COMAR 10.09.08.05-1.

Initial Here: _____ Date: _____

MANAGED CARE ORGANIZATION REIMBURSEMENT

This agreement to establish new reimbursement rates is made this _____day of _____, 2023, between the Maryland Department of Health (MDH) and _____, a Managed Care Organization (MCO).

I. MCO Reimbursement Rates

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) 2020 Medicaid Managed Care Rate Development Guide requires that states include a Medicaid MCO's rates into the HealthChoice Managed Care Organization Agreement, and amend the Agreement whenever the rates change in accordance with 42 CFR 438.7(c); and

WHEREAS, MDH has established new rates, as set forth in Appendix C, effective January 1, 2024.

1. MCO agrees to accept the reimbursement rates set forth in Appendix C, effective January 1, 2024.

2. MDH agrees to reimburse MCO at the rates set forth in Appendix C, effective January 1, 2024.

II. Mid-Year Acuity Adjustment for Calendar Year 2024

WHEREAS, in response to the Covid-19 and its impact on the economy and the Maryland Medicaid Managed Care Program, MDH has established the following mid-year acuity adjustment methodology for calendar year 2024:

1. MDH agrees to replace the disenrollment assumptions for disenrolled members and month of disenrollment with actual disenrolled members and month of disenrollment. MDH agrees to replace the MedicaidRx risk scores corresponding to the assumed disenrolled members with the MedicaidRx risk scores corresponding to the actual disenrolled members.

2. The CY24 mid-year acuity adjustment methodology will not require additional risk scores to be calculated, since the risk scores for all members captured in the CY21 base data were calculated when setting the original CY24 rates.

The table below shows the assumed leavers month of disenrollment, as shared at the June MCO rate setting meeting.

	F&C		CA	
Month of Disenrollment	Member Count	% of Total	Member Count	% of Total
Prior to June 2023	33,977	23.25%	39,216	35.85%
2023-06	10,271	7.03%	6,508	5.95%
2023-07	18,888	12.93%	7,943	7.26%
2023-08	21,118	14.45%	9,624	8.80%
2023-09	17,098	11.70%	8,114	7.42%
2023-10	18,331	12.55%	9,266	8.47%
2023-11	11,993	8.21%	7,135	6.52%
2023-12	2,952	2.02%	5,408	4.94%
2024-01	2,963	2.03%	4,329	3.96%
2024-02	2,557	1.75%	3,649	3.34%
2024-03	2,886	1.98%	3,677	3.36%
2024-04	3,083	2.11%	4,524	4.14%
Total	146,117	100.00%	109,393	100.00%

3. MCO agrees to accept the mid-year acuity adjustment methodology set forth in this Appendix C, effective January 1, 2024.

4. MDH agrees to reimburse the MCO in accordance with the mid-year acuity adjustment methodology set forth in this Appendix C, effective January 1, 2024.

III. HealthChoice Diabetes Prevention Program Risk Corridor for Calendar Year 2024

WHEREAS, in response to public health initiatives to prevent the spread of diabetes in Maryland, MDH has established and funded the HealthChoice Diabetes Prevention Program as a covered service by the MCO, and

WHEREAS, in response to utilization patterns of the HealthChoice Diabetes Prevention Program, MDH has established the following risk corridor for calendar year 2024:

1. The 2024 risk corridor will include target medical expenditure for each MCO of $0.31 per member per month (PMPM) for adults ages 18-64.

2. No reconciliation will occur for expenditures within a +/- 25% corridor of the target or between $0.24 and $0.39.

3. For expenditures below $0.24, the MCO must make a payment to MDH in the amount below $0.24 multiplied by applicable enrollment.

4. For expenditures above $0.39, MDH must make a payment to the MCO in the amount above $0.39 multiplied by applicable enrollment.

IV. HealthChoice Maternal and Child Health Initiative Risk Corridor for Calendar Year 2024

1. The 2024 risk corridor will include target medical expenditures for the MCO of $1.03 PMPM.

2. No reconciliation will occur for expenditures within a +/- 10% corridor of the target, or between $0.93 and $1.13.

3. For expenditures below $0.93, the MCO must make a payment back to MDH in the amount below $0.93 multiplied by enrollment.

4. For expenditures above $1.13, MDH must make a payment to the MCO in the amount above $1.13 multiplied by enrollment.

V. HealthChoice Collaborative Care Model Risk Corridor for Calendar Year 2024

1. The 2024 risk corridor will include target medical expenditures for the MCO of $0.96 PMPM.

2. No reconciliations will occur for expenditures within a +/- 10% corridor of the target, or between $0.86 and $1.05.

3. For expenditures below $0.86, the MCO must make a payment back to MDH in the amount below $0.86 multiplied by enrollment.

4. For expenditures above $1.05, MDH must make a payment to the MCO in the amount above $1.05 multiplied by enrollment.

[INSERT RATE TABLE]

IN WITNESS WHEREOF, the parties hereto have hereunder executed this Appendix the day and year first above written.

FOR MDH:

_____	_____
Date	Ryan B. Moran Deputy Secretary, Health Care Financing Medicaid Director Maryland Department of Health

FOR THE MCO:

_____	_____
Date	Signature
_____	_____

HEALTHCHOICE MCO PERFORMANCE MONITORING POLICIES

MDH may choose any of the performance enforcement options described, depending on the severity and persistence of the issue. MDH is not required to use the enforcement tools sequentially as a form of "progressive discipline." Rather, MDH may use its judgment and discretion, as the oversight agency with fiduciary responsibilities, to utilize the appropriate enforcement tool for the situation.

MDH reserves flexibility in the process and timing for rescinding penalties.

Network Adequacy
COMAR 10.67.05 sets forth network requirements for MCOs. MDH can act when MCOs are not in compliance with 10.67.05 and/or when a provider or recipient submits a complaint.

HEDIS Measures
MDH will send MCOs an annual HEDIS announcement letter containing the specific measures/elements for the measurement year at the start of the measurement year reporting cycle. Baseline measures and measures with trending breaks will not be reviewed as part of performance monitoring. The National HEDIS means (NHMs) used for the analysis will be sourced from the NCQA national HEDIS Medicaid HMO means and percentiles for the same measurement year, beginning with HEDIS Measurement Year 2022 and going forward. Performance monitoring comparisons for HEDIS Measurement 2021 and prior years were based on the NCQA national HEDIS Medicaid HMO means and percentiles from the prior HEDIS measurement year. Low HEDIS scores could result in a consumer report card star rating change or ineligibility for incentives in the Population Health Improvement Program (PHIP) Initiative. For purposes of trending, results from HEDIS Measurement Year 2020 will be removed from consideration when considering potential sanctions.

EPSDT/Healthy Kids Review
The minimum compliance score for each area is 80%. An assessment is performed for each MCO in each of the following EPSDT components: Health and Developmental History, Comprehensive Physical Examination, Laboratory Tests/At-Risk Screenings, Immunizations, and Health Education and Anticipatory Guidance.

Systems Performance Review
To relieve administrative burdens on MCOs, MDH switched to administering full SPRs for each MCO on a three-year cycle, beginning in SPR Reporting Year 2016 (Review Year CY 2015). On an annual basis, in order to assess MCO CAP implementation, auditors will only review elements or components which received a "partially met" or "unmet."

Performance Improvement Project Validation
Performance improvement projects (PIPs) are evaluated through the external quality review organization (EQRO) PIP Validation process. The EQRO PIP Validation follows the federal PIP validation protocol which assesses the effort and validity of the steps the MCO takes to reach the health outcome or satisfaction improvement goal. The first validation year that will be subject to Performance Monitoring findings will take place under calendar year 2025.

Part 1. Enforcement Guidelines – Minor Problems

	MCO Network Adequacy	HEDIS Performance	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/ Healthy Kids Review	Systems Performance Review (SPR)	Performance Improvement Project (PIP) Validation
Examples of Minor Problems	Minor provider or recipient complaint.	- One year with 35% or more elements with scores below the National Medicaid HEDIS Mean (NHM). - Two consecutive years with 35% or more elements with scores below the NHM.	Receives less than 80% in one or more components for a review year.	Does not receive a "Met" in an element or component.	Receives a "Low Confidence" finding on the annual EQRO PIP validation.
Enforcement	- Verbal request for clarification. - Corrective Action Plan (CAP) to prevent future a network adequacy problem. - Geo-Access Report.	Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options.	Written CAP within 45 days of presentation of preliminary report.	- Written CAP within 45 days of presentation of preliminary report. - Focused EQRO audit of specific elements/components on an annual basis.	- Letter to MCO advising of monitoring policy, PIP validation finding, and enforcement options, along with recommendations from MDH Intervention Evaluation Report.

Part 2. Enforcement Guidelines – Moderate Problems

	MCO Network Adequacy	HEDIS Performance	EPSDT/Healthy Kids Review	SPR	PIP Validation
Examples of Moderate Problems	Persistent minor provider or recipient complaints PCP to recipient ratio appears inadequate but recipients are still able to access a PCP.	Three years in a row or three years within a five-year period with 35% or more elements with scores below the NHM.	Receives less than 80% in one or more components for two review years -- this score could be for the same component or different components.	Receives an "Unmet" score two years in a row on the same element (without components) or an "unmet" or "partially met" score on the same component.	Receives a "Not Credible" finding on the annual EQRO PIP validation.
Enforcement	- Written CAP within 30 days of finding. - Geo-Access Report. - Financial sanctions. - Required to pay for out-of-network care and transportation.	- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options. - Freeze auto assignments in areas of the state as determined by MDH.	- Written CAP within 45 days of presentation of preliminary report. - Focused provider education project of specific component for two calendar years.	- Second Partially Met score on component will be changed to an Unmet score. - Written CAP within 45 days of presentation of preliminary report. - Focused EQRO audit of specific elements or components on an annual basis. - Monitoring of CAP by EQRO on quarterly basis, with failure to implement linked	- Letter to MCO advising of monitoring policy, PIP validation finding, and enforcement options, along with recommendations from MDH Intervention Evaluation Report. - Written CAP to address improvement of project plan to increase the confidence level.

				to freezing auto-assignments, freezing voluntary assignments, or financial sanctions.	

Part 3. Enforcement Guidelines – Major Problems

	MCO Network Adequacy	HEDIS Performance	EPSDT/Healthy Kids Review	SPR	PIP Validation
Examples of Major Problems	- Persistent PCP to recipient ratio appears inadequate (greater than 1:500) but recipients are still able to access a PCP. - No access to OB/GYN and/or no choice of PCP.	- Four years in a row or four years within a five-year period with 35% or more elements with scores below the NHM.	Receives less than 80% in one or more components for three consecutive years, or for three years within a five-year period – this score could be for the same component or different components.	Receives an "Unmet" score three or more years in a row on the same element (without components) or an "unmet" or "partially met" score on the same component.	Receives a "Not Credible" finding on the EQRO PIP validation for two or more years during the PIP project cycle.
Enforcement	- CAP within 10 days of finding. - Geo Access Report. - Financial Sanction. - Required to pay for out-of-network care and transportation.	- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options.	- Written CAP within 45 days of presentation of preliminary report. - Monitoring of CAP by EQRO on quarterly basis, with failure to implement linked to freezing	- Second Partially Met score on component will be changed to an Unmet score. - Written CAP within 45 days of presentation of	- Written CAP to address improvement of project plan to increase the confidence level. - Continuation of project until

	- Allow recipients in problem service area(s) to voluntarily disenroll from MCO immediately. - Freeze auto assignments in problem service area(s). - Freeze voluntary enrollment in problem service area(s). - Freeze the MCO to all future enrollment in problem service area(s) (moving current recipients into another MCO of their choice). - Additional financial sanctions beyond paying for out-of-network care and transportation. - Contract termination/MCO closure in all affected counties.	- Freeze auto assignments in areas of the state as determined by MDH. - Freeze voluntary enrollment in areas of the state as determined by MDH. - Financial sanctions other than enrollment freeze. - Contract termination and MCO closure in all counties.	auto-assignments or financial sanctions. - Focused provider education project of specific component for three calendar years. - Freeze auto assignments in areas of the state determined by MDH.	preliminary report. - Focused EQRO audit of specific elements or components on an annual basis. - Monitoring of CAP by EQRO on quarterly basis, with failure to implement linked to freezing auto-assignments, freezing voluntary assignments, or financial sanctions. - Application of financial sanctions.	permitted to sunset by MDH.

MANAGED CARE ORGANIZATION SERVICE AREA PARTICIPATION AND OPTIONAL SERVICES AND BENEFITS

This agreement to designate Service Area Participation and Optional Services or Benefits is made this _____day of _____, 2023, between the Maryland Department of Health (MDH) and _____, a Managed Care Organization (MCO).

A. Definitions.

All terms capitalized herein shall have the same meaning as those in the HealthChoice Managed Care Organization agreement, except that the following terms shall have the meanings stated:

1. "Participation" means the arrangement under which the MCO arranges for and/or provides services to Enrollees in approved Service Areas, subject to applicable provisions of federal law, the Maryland Code, COMAR, transmittals, and guidelines issued by MDH in effect at any time during the term of this Agreement. "Participation" includes the MCO's enrollment of Medicaid recipients who have selected the MCO and those auto-assigned by MDH.

2. "Service Areas" means the 23 counties and Baltimore City that comprise the State of Maryland.

3. "Open" means any Service Area that the MCO has participated in during the previous calendar year.

4. "Closed" means any Service Area in which the MCO has never participated.

5. "Involuntarily Frozen" means any Service Area in which MDH freezes the auto-assignment of enrollees in a Service Area, for reasons including, but not limited to, insufficient provider networks and imposition of sanctions.

6. "Voluntarily Frozen" means any Service Area in which the MCO requests freezing the auto-assignment of enrollees. Being "Voluntarily Frozen" remains in effect for two calendar years.

7. "Request to Open" means a request by the MCO to Open any Service Area that was previously Closed, Voluntarily Frozen, or Involuntarily Frozen, pending review and approval by MDH.

8. "Optional Service or Benefit" means any service that the MCO voluntarily agrees to provide whose cost is not included in the capitation rates determined in Appendix C or future iterations of this Agreement.

B. The MCO agrees:

1. To express its intent to Open, Request to Open, or request to be Voluntarily Frozen in a Service Area during the term of this Agreement, effective January 1, 2024, as identified in this Appendix in accordance with 42 CFR 438.207;

2. That a Request to Open and a request to be Voluntarily Frozen are subject to review and approval by MDH before they become effective;

3. That MDH's approval of a request to be Voluntarily Frozen in a Service Area does not stay any obligation under this Agreement to accept and serve Enrollees who select the MCO;

4. To provide the Optional Services or Benefits during the term of this Agreement, effective January 1, 2024, as identified in this Appendix in accordance with 42 CFR 438.3(e);

C. MDH and the MCO agree:

1. That the costs of any Optional Services or Benefits shall not be included when determining the capitation rates identified in Appendix C of this Agreement or future capitation rate calculations; and

2. That the provision of services identified in this Appendix is subject to approval of this Agreement by the Centers for Medicare and Medicaid Services.

MCO SERVICE AREA PARTICIPATION

Service Area	Current Participation Status	No Change	Request to Open	Request to Voluntarily Freeze Enrollment
Allegany				
Anne Arundel				
Baltimore City				
Baltimore County				
Calvert				
Caroline				
Carroll				
Cecil				
Charles				
Dorchester				
Frederick				
Garrett				
Harford				
Howard				
Kent				
Montgomery				
Prince George's				
Queen Anne's				
St. Mary's				
Somerset				
Talbot				
Washington				
Wicomico				
Worcester				

OPTIONAL BENEFITS OFFERED BY THE MCO

Benefit	Population	Limitations (if applicable)	Effective Date

IN WITNESS WHEREOF, the parties hereto have hereunder executed this Appendix the day and year first above written.

FOR MDH:

_____	_____
Date	Ryan B. Moran Deputy Secretary, Health Care Financing Medicaid Director Maryland Department of Health

FOR THE MCO:

_____	_____
Date	Signature
_____	_____

HEALTHCHOICE NETWORK ADEQUACY STANDARDS

To comply with the requirements of 42 CFR 438.68, MDH is responsible for developing minimum time and distance standards for HealthChoice MCO provider networks. MDH developed these standards by adapting the Health Service Delivery (HSD) standards for Maryland Medicare Advantage plans and the current HealthChoice regional and distance network standards. For each provider type, MCOs must meet either the time or distance standard for each county in the MCO's service area.

	Urban[1]		**Suburban[2]**		**Rural[3]**	
Provider Type	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)
Primary Care	15	10	30	20	40	30
Primary Care - Pediatric	15	10	30	20	40	30
Pharmacy	15	10	30	20	40	30
Diagnostic Laboratory/X-Ray	15	10	30	20	40	30
Gynecologists	15	10	30	20	40	30
Obstetricians	15	10	30	20	90	75
Prenatal Care Providers[4]	15	10	30	20	90	75
Acute Inpatient Hospitals	20	10	45	30	75	60
Core Specialties (Cardiology, ENT, Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, Urology)	30	15	60	45	90	75
Major Specialties (Allergy and Immunology, Dermatology, Endocrinology, Infectious Diseases, Nephrology, Pulmonology)	30	15	80	60	110	90
Pediatric Sub-Specialties (Cardiology, Gastroenterology, Neurology, Surgery)	30	15	80	60	250	200

[1] Urban Counties: Baltimore City
[2] Suburban Counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, Prince George's
[3] Rural Counties: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, Worcester
[4] Prenatal Care providers is inclusive of family practitioners who provide prenatal care and perform deliveries, obstetricians, gynecologists, and certified nurse midwives.

ADDITIONAL NETWORK REQUIREMENTS

HealthChoice MCOs must meet all network requirements set forth in COMAR 10.67.05, including:

1. Offering an appropriate range of preventive, primary care, and specialty services adequate for the anticipated number of Enrollees in the MCO's service areas.
2. Maintaining a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the number of Enrollees in the MCO's service areas.
3. Ensuring that in-plan individual practitioners, based on full-time equivalency, are assigned no more than the number of enrollees that is consistent with a 200:1 ratio of enrollee to practitioner in the local access area.
4. Maintaining written policies and procedures for selecting and retaining network providers in accordance with the requirements of 42 CFR 438.214 and the applicable provider panel provisions of Maryland Insurance Article § 15-112, Code Ann.
5. Ensuring that all network providers are screened, enrolled, and revalidated by the State as Medicaid providers, in accordance with 42 CFR part 455, subparts B and E, and validate enrollment by verifying against MDH's full fee-for-service provider file.
6. Accepting the Maryland Uniform Credentialing Form for the credentialing of network providers.
7. Refraining from discriminating against providers serving high-risk populations or specializing in conditions requiring costly treatment.
8. Informing all providers at the time of entering into a contract with the MCO about the grievance and appeal system, as set forth in 42 CFR 438.414 and 42 CFR 438.10(g)(2)(xi).
9. Monitoring MDH's correspondence and any database publicizing Department-initiated terminations of providers from the Program.
10. Terminating the contract of, or refraining from contracting with, providers terminated or excluded from participating in the Program.
11. Developing and distributing a provider manual that includes all of the information provided in MDH's template and required in COMAR 10.67.05.04A(2).
12. Ensuring services are delivered in a culturally competent manner to all enrollees, including enrollees with limited English proficiency; enrollees with diverse cultural and ethnic backgrounds; and enrollees of all genders, sexual orientations, and gender identities.
13. Ensuring its provider network can provide physical access, reasonable accommodation, and accessible equipment for Enrollees with physical or mental disabilities.
14. Providing necessary services covered under the contract out of network adequately and timely for a particular Enrollee, for as long as the MCO's provider network is unable to provide them.
15. Doula Quantitative Network Adequacy Standards (**Included for Informational Purposes Only**)
    a. For urban areas (Baltimore City), MCOs are required to have a minimum of four doulas.
    b. For suburban areas (Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, and Prince George's counties), MCOs are required to have a minimum of four doulas serving each county.

c. For rural areas in the Eastern Shore region (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties), MCOs are required to have a minimum of two doulas serving the region.
d. For rural areas in Southern Maryland (Calvert, Charles, and St. Mary's counties), MCOs are required to have a minimum of two doulas serving the region.
e. For rural areas in Western Maryland (Allegany, Garrett, Frederick, and Washington counties), MCOs are required to have a minimum of two doulas serving the region.

MONITORING AND ENFORCEMENT

HealthChoice MCOs will be required to give assurances to MDH annually, along with supporting documentation, demonstrating their provider network's capacity to serve enrollees in a format specified by MDH. When an MCO cannot demonstrate adequate coverage for 90% of enrollees in a service area at the required time or distance, MDH may freeze auto-assignments in the impacted service area.

When an MCO proposes expansion into a new county, MDH will evaluate its provider network according to the time and distance standards in that service area. If the MCO can demonstrate adequate coverage for 90% of enrollees at the required time or distance standards in the county for each provider type, MDH will allow the MCO to open in that county.

If an MCO can otherwise demonstrate to MDH's satisfaction the adequacy of its provider network notwithstanding its inability to meet these requirements, MDH may, in its discretion, approve the network if special circumstances exist which, considered along with the overall strength of the MCO's network, establish that MDH's approval of the network will enhance recipients' overall access to quality health care services in the area to be served.

CMS Medical Loss Ratio (MLR) Standards
CY 2023

MCO Name: MCO Provider Number(s):

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF MCO

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying information prepared by _____ (MCO name) for the CMS MLR reporting period beginning _____ and ending _____, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the MCO in accordance with 42 CFR §438.8, except as noted.

_____
(Signed)

Chief Financial Officer or Administrator of MCO(s)

_____
Title

_____
Date

_____
Name and Telephone Number of Person to Contact for More Information

Instructions for completion of Medical Loss Ratio (MLR) Reporting Template

42 CFR §438.8 - Medical Loss Ratio (MLR) standards

States must require that MCOs calculate and report an MLR for the rating period that begins in 2023

Worksheet 2 (Reporting Template)

Line 1: MCO Reporting: Name of MCO

Line 2: Incurred Period: Period (calendar year) services were incurred

Line 3: Report date: As of June 30th following the incurred period

Line 4: Contact Name: MCO contact name

Line 5: Phone Number of MCO contact

Line 6: e-mail address of MCO contact

Line 7: Due date of submission to MDH: September 1st following the incurred period

Line 8: MLR Calculation - Please complete lines i. through vi. And line xi (lines viii. - x. are calculated cells)

Worksheet 3 (Credibility Table) - Table developed by CMS Office of the Actuary

The calculation illustrated in cell C17 is for annual member months between 48,000 or 96,000. Please modify cell C17 to reflect the range of your annual member months.

MCOs with annual member months greater than 380,000 would have a credibility adjustment of zero.

Attestation MLR form - In addition to submission of this Excel file, please complete the Word version of the attached attestation document.

In addition to completing this file and separate attestation document, please provide the following:

1. Include a separate audited financial underwriting exhibit reflecting HealthChoice only experience for the current reporting year.

2. Provide documentation (as needed) supporting the methodology used to allocate expenses under multiple expense categories as stated on the reporting template in worksheet 2.

MARYLAND HEALTHCHOICE ONLY PRODUCT LINE

1. MCO Reporting: MCO A

2. Incurred Period: January 1, 2023 - December 31, 2023

3. Reported as of: June 30, 2024

4. Contact Person: Jane Doe

5. Phone Number: xxx-xxx-xxxx

6. E-mail Address: abc@def.com

7. Report due to MDH: September 1, 2024

8. MLR Calculation:

(Notes)		(Aggregate for all Medicaid Eligibility Groups)	(Sample Calculation)
	Reporting Components:		
	(i.a) Total incurred claims.		$ 47,400,000
	(i.b) PBM Spread (admin & profit) reported in i.a.		$ -

	(i.c.) Total net incurred claims (i.a – i.b)	**$ 47,400,000**
42 CFR §438.8(e)(3)	**(ii) Expenditures on quality improving activities.**	**$ 900,000**
(Program Integrity Requirements)	**(iii) Expenditures related to activities compliant with 42 CFR §438.608(a)(1) through (5), (7), (8) and (b).**	**$ 150,000**
	(iv) Non-claims costs.	**$ 6,450,000**
	(v) Premium revenue.	**$ 60,000,000**
Split between Prem & Inc. Tax	**(vi) Taxes, licensing and regulatory fees.**	**$ 1,840,000**
	(vii) Methodology(ies) for allocation of expenditures.	See instructions worksheet

(ix) Any credibility adjustment applied.	**2.40%**
(x) The calculated MLR (after credibility adjustment)	**85.4%**
(xi) Any remittance owed to the State, if applicable.	**$ -**
(xii) Member Months	**75,000**

Credibility Table for Medicaid and CHIP Managed Care Plans effective for services incurred January 1, 2017*

Reporting Year Member Months	Credibility Adjustment
< 5,400	Non-credible
5,400	8.40%
12,000	5.70%
24,000	4.00%
48,000	2.90%
96,000	2.00%
192,000	1.50%
380,000	1.00%
>380,000	Fully Credible

*Adjustment applied rounded to the nearest tenth using linear interpolation.
Same table (developed by CMS Office of the Actuary) as provided in last year's template

Member Months	**Calculated Adjustment**
75,000	**2.40%**

(Note: as needed, please adjust formula to reflect your actual member months)

MATERNAL OPIOID MISUSE (MOM) PROGRAM

Per the approved §1115 HealthChoice demonstration waiver for the period of calendar years 2022-2026, MCOs will implement the MOM program.

Under the MOM program, MDH will pay HealthChoice MCOs a per-member-per-month (PMPM) payment to provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination. In addition to the care planning and social determinants of health screening activities conducted at intake, MCO case managers will also be responsible for a minimum of at least one monthly connection with MOM participants. In addition, MCOs must ensure each participant receives at least one somatic or behavioral health service per month.

The MOM intervention provides services distinct from case management and care coordination services already available to Maryland Medicaid beneficiaries. MCOs must offer MOM case management services to eligible members as a first option.

Following is a description of the MOM program intervention funded via §1115 authority. Additional detail on implementation and documentation requirements can be found in the MOM Case Management Manual, available at https://health.maryland.gov/mmcp/Pages/MOM-Model.aspx.

I. CASE MANAGEMENT SERVICES

A. **Intake**: Prior to MOM program intake, Maryland Medicaid MCOs will engage in a continuous "no wrong door" approach to identifying potential MOM program participants. MCOs will make every concerted effort to identify eligible members from multiple sources, *e.g.,* local health departments, local behavioral health authorities, community-based organizations, and provider referrals.

B. **Assessment**: Once an individual consents to participate in the MOM program the MOM case manager will conduct a set of standard screenings, intended to inform the collaborative development of a care plan and will be revisited at various intervals during MOM program participation, such as health-related social needs. After delivery and during the postpartum period, reassessments will center on the infant-mother dyad, with a focus on parenting, managing stress and other activities that will contribute to a stable and healthy family environment for the infant and reduce the risk of recurrence of use or overdose.

C. **Creation of a Treatment Plan**: Each participant will work jointly with their MOM case manager during the intake session to develop an initial care plan, which will collect information on all providers who the participant sees for

healthcare. Using participant engagement best practices such as motivational interviewing and shared decision-making, the MOM participant will work with their MOM case manager to identify two to three goals based on their identified needs, with time-based and achievable objectives for each goal. The MOM case manager will check in with the participant on their progress towards achieving each goal, addressing needs identified through the assessment and identifying any barriers to completing the goals.

D. **Coordination**: Each participant will be engaged in MOM program services from the time of intake up until 12-months postpartum or until they lose Medicaid eligibility, unless they opt out or become lost to follow-up (after substantial outreach, below) before that time. On a monthly basis, each participant will receive the following five core components of care coordination:

1. Comprehensive case management;
2. Care coordination;
3. Health promotion;
4. Individual and family supports; and
5. Linkages to community and support services.

Each participant will receive support from their case managers to ensure they are able to attend their appointments; this may include arranging for transportation, peer support, or other supports that facilitate the keeping of scheduled medical appointments and thus remain engaged in the MOM program.

E. **Referral:** Each participant will work jointly with their case managers to develop an individualized plan when transitioning from MOM program services. Participants will review the goals developed for their care plan, determine areas that may need continued support, and work with their MCO case managers to perform warm handoffs to other programs if warranted.

F. **Outreach to Disengaged Participants**: Substantial outreach is a specific protocol for re-engaging participants should they become disengaged from care (e.g., miss a doctor's appointment or miss a monthly case manager contact). Per month of substantial outreach, case managers will need to make and document at least three outreach attempts, two of which must be different types of follow-up (e.g., two phone calls and one letter in the mail).

II. PAYMENT

A. MDH will provide a PMPM reimbursement of:

1. $208 in accordance with Section I(A)-(E), to provide intake and ongoing case management services; and
2. $207 in accordance with Section I(F), to provide substantive outreach services.

B. Payment of PMPM reimbursement is contingent upon compliance with the documentation and reporting requirements outlined in Section I.

HEALTHCHOICE FINANCIAL SANCTION POLICY

This policy outlines financial sanctions that the Maryland Department of Health (MDH) may levy on Managed Care Organizations (MCOs). It does not address other sanctions available under COMAR 10.67.10 which may be used in addition to or instead of the financial sanctions described in this policy.

MDH may impose any of the financial sanctions described, depending on the severity and persistence of the issue. MDH is not required to use the sanctions sequentially as a form of "progressive discipline." Rather, MDH may use its judgment and discretion, as the oversight agency with fiduciary responsibilities, to utilize the appropriate sanction for the situation. MDH reserves flexibility in the process and timing for rescinding sanctions.

DEFINITIONS

Corrective Action Plan: A written, detailed plan to address non-conformity with a law, regulation, contract term, policy, or deadline.

Deficiency: A failure to comply with any applicable law, regulation, contract term, policy, or deadline established by MDH or its designees. Each failure to comply is a separate deficiency.

FINANCIAL SANCTION GUIDELINES

1. MDH may impose any of the financial sanctions described below.

2. MDH shall notify an MCO of a deficiency in writing to explain the basis and nature of the deficiency, as well as any sanctions MDH will impose.

3. For any deficiency, MDH may impose a sanction of up to $1,000,000 multiplied by the MCO's market share percentage at the beginning of the term of the Agreement in effect.

    a. The notice may include an opportunity for the MCO to submit a plan to take corrective action. The corrective action plan (CAP) will be subject to the review and approval of MDH.

    b. Should the MCO submit and implement a CAP and it fails to remedy the identified deficiencies, MDH may impose the following financial sanctions, in addition to any sanctions initially imposed for the deficiency:

        i. One failure to implement: up to $100,000 multiplied by the MCO's market share percentage;
        ii. Two failures to implement: up to $500,000 multiplied by the MCO's market share percentage; and
        iii. Three or more failures to implement: up to $1,000,000 multiplied by the MCO's market share percentage.

4. If the deficiency involves a failure to submit a report or CAP, submission of an inaccurate or incomplete report or CAP, or a failure to provide other information requested by MDH or its designee, MDH may impose a sanction of $250 for each calendar day the information has not been submitted or is late, inaccurate, or incomplete.

    a. An MCO may request an extension and guidance up to 24 hours prior to the deadline for submission, which MDH may approve or deny.

    b. The sanction will be applied at 5:00 PM on each day the information is not submitted, inaccurate, or incomplete.

    c. MDH may double the total sanction assessed for each 14-day period that the information has not been submitted or is late, inaccurate, or incomplete.

5. Any financial sanctions described in this policy or implemented under this policy shall not preclude or otherwise impact MDH's pursuit and recovery of actual damages incurred by MDH resulting from the MCO's deficiencies related to its duties and obligations as an MCO in the HealthChoice program.

6. Financial sanctions will be deducted from the MCO's capitation payment and deposited in the HealthChoice Performance Incentive Fund, in compliance with Health-General Art. § 15-103.3.

7. This policy shall apply, at MDH's discretion, to noncompliance regardless of the timing of the noncompliant activity.

MARYLAND QUALITY INCENTIVE PROGRAM (M-QIP) REQUIREMENTS

Contingent on CMS approval, and in accordance with the federal Medicaid directed payment language in 42 CFR 438.6, the M-QIP Program will be implemented to improve quality outcomes, reduce ED utilization for Ambulatory Sensitive Conditions, and increase access to specialty care. The program applies to physician and certain non-physician practitioners employed by or affiliated with the University of Maryland.

I. Eligible Providers as defined below will be eligible for enhanced payments for patient care services provided. For purposes of M-QIP, an Eligible Provider is limited to the following provider types employed by or affiliated with the Faculty Physicians Inc. (FPI) at the University of Maryland:

   A. Doctors of Medicine
   B. Doctors of Osteopathy
   C. Certified Registered Nurse Anesthetists (CRNAs)
   D. Certified Registered Nurse Practitioners
   E. Physician Assistants
   F. Certified Nurse Midwives (CNMs)
   G. Clinical Social Workers (CSWs)
   H. Clinical Psychologists
   I. Optometrists
   J. Physical Therapist
   K. Occupational Therapist
   L. Speech Therapist
   M. Audiologists

II. A subset of Eligible Providers participates in the Maryland Primary Care Program (MDPCP), for which HealthChoice will begin quality alignment in CY 2023 and payment alignment starting in CY 2024. In order to prevent duplicative quality-based payments in the aligned program, beginning in CY 2024, M-QIP payments will be adjusted to account for Eligible Provider participation in and meeting of MDPCP quality metrics.

III. The M-QIP program applies only to MCOs that have a contract with FPI. The MCO will not be responsible for services that they do not cover or are carved out of the HealthChoice Benefit Package.

IV. The MCO shall continue to pay their negotiated base rates to eligible providers throughout the year.

V. M-QIP will be funded through a separate payment term pool. The separate payment term pool will contain a set dollar amount for each contract period.

V. MCOs contracted with FPI will receive quarterly payments from MDH. These MCOs will be required to reimburse FPI from these funds according to a schedule determined by MDH.

HEALTHCHOICE DIABETES PREVENTION PROGRAM (DPP) FEE SCHEDULES

There are two reimbursement methodologies available to MCOs for HealthChoice DPP. **MCOs are required to pay contracted CDC-recognized type 2 diabetes prevention programs at least the minimum rates outlined in each methodology.**

Section I outlines the session and performance payment approach for reimbursing in-person and virtual CDC-recognized type 2 diabetes prevention programs. Section II outlines the milestone/bundled payment approach for reimbursing virtual CDC-recognized type 2 diabetes prevention programs only.

Section 1: HealthChoice Session and Performance-Based Reimbursement Methodology for In-Person and Virtual DPP Providers

Participating in-person and virtual CDC-recognized type 2 diabetes prevention programs must use the make-up modifiers when submitting claims for make-up sessions using TS and VM modifiers with any code that has a session attached to it (except for the first session). In-person programs should always use the TS modifier for makeup sessions.[5] Virtual programs should always use the VM modifier for their makeup sessions.

HCPCS code G9891 is a code used to track attendance and indicate that the CDC-recognized type 2 diabetes prevention program furnished a session that was not accounted for using an attendance performance goal code, such as G9874 (4 core sessions attended). G9891 is a non-payable code for reporting services of sessions furnished to participants (i.e. core sessions 2-3, 5-8, and 10-16).

Table 1. *HealthChoice DPP Session-Based Reimbursement Methodology for Minimum Payment Levels for In-Person and Virtual DPP Providers*

Session/Event	HCPCS Code and Description	Payment	Modifiers			Limitation
			In-Person Make-up Session	Virtual Session [6]	Virtual Make-Up Session	
Session 1	G9873[7] - 1st core session attended	$100	None	GT[8]	None	Can be used 1 time in 365 days[9]
Session 2-4	G9874 - 4 total core sessions attended[10]	$120	TS[11]	GT	VM[12]	Can be used 1 time in 365 days[9]

[5] In-person programs may conduct make-up sessions online, via some other virtual modality, or over the phone; these are still considered to be delivering the program in-person.

[6] Virtual DPP refers to online, distance learning or combination delivery modes (combination only when online and distance learning DPP services are rendered).

[7] CDC-recognized type 2 diabetes prevention programs must have confirmed self-referred individuals' eligibility through a blood test, or provider note indicating history of GDM, prior to billing for this code.

[8] The modifier GT refers to "via interactive audio and video telecommunications systems."

[9] In cases where MCOs allow individuals to switch DPP Providers after starting the program, the MCO may need to make an exception to the "can be used 1 time in 365 days" limitation.

[10] Bill with counter code G9891 two times to indicate completion of core sessions 2 and 3.

[11] The modifier TS refers to "follow-up service." In-person programs may only use TS to indicate a makeup session of any modality.

[12] The modifier VM refers to "virtual make-up session." Virtual programs may only use VM to indicate a makeup session.

						Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS
Session 5-9	G9875 - 9 total core sessions attended[13]	$140	TS	GT	VM	Can be used 1 time in 365 days[9] Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS
Session 10-19	G9876 - 2 core maintenance sessions attended in months 7-9 (weight-loss goal not achieved or maintained)[14]	$40	TS	GT	VM	Can be used 1 time in 365 days[9] Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS
Session 20-22	G9877 - 2 core maintenance sessions attended in months 10-12 (weight loss goal not achieved or maintained)[15]	$40	TS	GT	VM	Can be used 1 time in 365 days[9] Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS
Number of Sessions	G9891[16] - MDPP session reported as a line-item on a claim for a payable MDPP service	$0	None	GT	None	This CPT code is used to track attendance. This is a non-payable code for reporting services of sessions furnished to participants (i.e. core sessions 2-3, 5-8, and 10-16.)

Performance Payments

HCPCS codes G9878 and G9879 are both enhanced payments for performance: weight loss achieved or maintained for months 7-9 and 10-12. These codes may only be used in conjunction with either HCPCS code G9880 (5% weight loss) or G9881 (9% weight loss).

[13] Bill with counter code G9891 four times to indicate completion of core sessions 5, 6, 7, and 8.

[14] Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 7-9.

[15] Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 10-12.

[16] A HCPCS G-code for a session furnished by the billing supplier that counts toward achievement of the attendance performance goal for the payable MDPP services HCPCS G-code. This CPT code is used to track attendance. This is a non-payable code for reporting services of sessions furnished to participants (i.e. core sessions 2-3, 5-8, and 10-16.)

Table 2. *HealthChoice DPP Performance-Based Reimbursement Methodology for In-Person and Virtual DPP Providers*

Session/ Event	HCPCS Code and Description	Payment	Modifiers			Limitation
			In-Person Make-up Session	Virtual Session	Virtual Make-Up Session	
5% Weight Loss	G9880 – 5 percent weight loss from baseline achieved	$100	None	GT8	None	Can be used 1 time in 365 days[9]
9% Weight Loss	G9881 – 9 percent weight loss from baseline achieved	$50	None	GT	None	Can be used 1 time in 365 days[9]
Session 10-19 with at least 5% weight loss	G9878[17] - 2 core maintenance sessions attended in months 7-9 and weight loss goal achieved or maintained	$80	TS11	GT	VM12	Can be used 1 time in 365 days[9] Cannot be used with G9876 Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS
Session 20-22 with at least 5% weight loss	G9879[18] - 2 core maintenance sessions attended in months 10-12 and weight loss goal achieved or maintained	$80	TS	GT	VM	Can be used 1 time in 365 days[9] Cannot be used with G9877 Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS

Assuming the enrollee attends all sessions and all performance outcomes are met, the total payment per enrollee for the CDC-recognized type 2 diabetes prevention programs based on these rates is $670.

[17] In order to bill G9878 for enhanced attendance, must also bill or have previously billed for weight loss achieved from baseline at either 5% (G9880) or 9% (G9881). Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 7-9.

[18] In order to bill G9879 for enhanced attendance in this period, must also bill or have previously billed for weight loss achieved from baseline at either 5% (G9880) or 9% (G9881). Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 10-12.

For community and/or virtual DPP providers whose organizations do not meet the descriptions provided for the place of service code set, they may use the place of service code '99'.[19]

These HCPCS codes may not be billed with or as nutritional counseling, evaluation and management codes, or other procedure codes when billing for the National DPP lifestyle change program.

Section II: HealthChoice Milestone/Bundled Reimbursement Methodology for Virtual DPP Providers[6]

Table 3, below, lists the recommended HCPCS codes and reimbursement for HealthChoice DPP under the virtual DPP milestone/bundled reimbursement methodology. Flexibility in bundled payment distribution across milestones 1-3 and the 5% and 9% performance payouts will be allowed so long as the total payment per enrollee for the CDC-recognized type 2 diabetes prevention program meets or exceeds $670.

Table 3. *HealthChoice DPP Milestone/Bundled Reimbursement Methodology for Virtual DPP Providers*

Session/Event	HCPCS Code and Description	Payment	Modifiers			Limitation
			In-Person Make-up Session	Virtual Session[6]	Virtual Make-Up Session	
Milestone 1: May be billed at enrollment or initiation into program; scale is issued; or 1st core session attended	Available codes: G98736 - 1st core session attended E1639[20] 0488T[21]	$220	Not applicable	GT8	None	Can be used 1 time in 365 days[9]
Milestone 2: Billed at 4 core sessions attended	G9874 - 4 total core sessions attended	$160	Not applicable	GT	VM12	Can be used 1 time in 365 days[9] Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS
Milestone 3: Billed at 9 core sessions attended	G9875-9 core sessions attended	$140	Not applicable	GT	VM	Can be used 1 time in 365 days[9] Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS

[19] Place of service code '99' refers to "Other place of service not identified above." Centers for Medicare and Medicaid Services. (2016). Place of Service Code Set: Place of Service Codes for Professional Claims. Retrieved from: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

[20] E1639: Durable Medical Equipment (DME)

[21] 0488T: Preventive behavior change, online/electronic intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days

Performance: 5% weight loss achieved	G9880 – 5 percent weight loss from baseline achieved	$125	Not applicable	GT	None	Can be used 1 time in 365 days[9]
Performance: 9% weight loss achieved	G9881 - 9 percent weight loss from baseline achieved	$25	Not applicable	GT	None	Can be used 1 time in 365 days[9]

As indicated for Milestone 1, MDH will accept one of three possible codes for enrollment or initiation into the program as a first milestone and allow claiming for the scale using either 1) G9873; 2) E1639; or 3) 0488T.

Assuming the enrollee attends and meets all milestones and achieves the 5% and 9% performance outcomes, total payment per enrollee for virtual CDC-recognized type 2 diabetes prevention programs based on these rates should equal $670.

ICD-10 Diagnosis Codes, Descriptions and DPP Provider Assignment Guidance

The following ICD-10 diagnosis codes may be used for billing:

Table 4. *Elevated Blood Glucose Level and Gestational Diabetes ICD-10 Codes*

ICD-10 Code	Description – Elevated Blood Glucose Level	ICD-10 Code	Description - Gestational Diabetes
R73.01	Impaired fasting glucose	Z86.32[22]	Personal history of gestational diabetes
R73.02	Impaired glucose tolerance - Oral	R73.03	Prediabetes

Table 5. *BMI ICD-10 Codes for BMI 23.0 and greater*

ICD-10 Code	Description – Body Mass Index	ICD-10 Code	Description – Body Mass Index
Z68.23	Body mass index (BMI) 23.0-23.9, adult	Z68.34	Body mass index (BMI) 34.0-34.9, adult
Z68.24	Body mass index (BMI) 24.0-24.9, adult	Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.25	Body mass index (BMI) 25.0-25.9, adult	Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.26	Body mass index (BMI) 26.0-26.9, adult	Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.27	Body mass index (BMI) 27.0-27.9, adult	Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.28	Body mass index (BMI) 28.0-28.9, adult	Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.29	Body mass index (BMI) 29.0-29.9, adult	Z68.41	Body mass index (BMI) 40.0-44.9, adult

[22] DPP providers should include Z86.32 as primary code for all individuals indicating history of gestational diabetes after confirming not currently pregnant.

Z68.30	Body mass index (BMI) 30.0-30.9, adult	Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.31	Body mass index (BMI) 31.0-31.9, adult	Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.32	Body mass index (BMI) 32.0-32.9, adult	Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.33	Body mass index (BMI) 33.0-33.9, adult	Z68.45	Body mass index (BMI) ≥ 70, adult

HIGH-COST LOW VOLUME DRUG RISK MITIGATION POLICY

Maryland's Department of Health (MDH) has instituted a risk mitigation policy, effective January 1, 2021, to protect the HealthChoice program from utilization fluctuations related to very high-cost drugs. The policy covered both Physician Administered Drugs and retail pharmacy drugs that had an expected annual cost over $400,000. For CY 2024, the policy has been updated to include drugs with an annual cost of over $500,000. The specific drugs covered are listed in Exhibit I of this document. The list of drugs is subject to change during the year if a new drug received FDA approval and is a covered Medicaid service with an expected annual cost over $500,000. No previously approved and covered drugs will be added to the list during the year. If a new drug is approved and reaches the market after this analysis is complete, MDH will evaluate the expected cost of the drug at the NDC level and will add it to the list if the expected annual cost is over $500,000. The list of covered drugs will be reviewed annually to add in drugs that have increased in price or remove drugs that have decreased in price.

Under this new mitigation policy, costs of the High-Cost Low Volume drugs listed in Exhibit I are removed from the rate setting base data and are not included in the standard capitation rate paid to HealthChoice Managed Care Organizations (MCOs). The MCOs are still responsible for authorizing, managing, and paying all claims related to the high-cost drugs, and will invoice MDH for any incurred expenses on a quarterly basis. The MCOs are expected to develop and adhere to medical necessity criteria to ensure that all instances of utilization of drugs listed in Exhibit I follow best clinical practices. MDH reserves the right to audit medical necessity criteria and review the utilization of all High-Cost Low Volume Drugs to ensure adherence to appropriate criteria.

Exhibit I – List of NDCs and J-Codes Covered by High-Cost Low Volume Risk Mitigation Policy (Revised September 2023)

Drug Name	NDC Code	HCPCS Code (if Applicable)
Actimmune	**75987-0111-11, 75987-0111-10**	**J9216**
Adcetris	**51144-0050-01**	**J9042**
Altuviiio	**71104-0978-01, 71104-0979-01, 71104-0980-01, 71104-0981-01, 71104-0982-01, 71104-0983-01, 71104-0984-01**	**J7199**
Amondys 45	**60923-0227-02**	**J1426**
Benefix	**58394-0633-03, 58394-0634-03, 58394-0635-03, 58394-0636-03, 58394-0637-03**	**J7195**
Blincyto	**55513-0160-01**	**J9039**
Bylvay	**74528-0040-01, 74528-0120-01**	**J8499**
Cinryze	**42227-0081-05**	**J0598**
Danyelza	**73042-0201-01**	**J9348**
Daybue	**63090-0660-01**	**J8499**
Elevidys	**60923-0501-10 , 60923-0502-11 , 60923-0503-12, 60923-0504-13, 60923-0505-14 , 60923-0506-15 , 60923-0507-16, 60923-0508-17, 60923-0509-18, 60923-0510-19, 60923-0511-20, 60923-0512-21, 60923-0513-22, 60923-0514-23, 60923-0515-24, 60923-0516-25, 60923-0517-26, 60923-0518-27, 60923-0519-28, 60923-0520-29, 60923-0521-30, 60923-0522-31, 60923-0523-32, 60923-0524-33, 60923-0525-34, 60923-0526-35, 60923-0527-36, 60923-0528-37, 60923-0529-38, 60923-0530-39, 60923-0531-40, 60923-0532-41, 60923-0533-42, 60923-0534-43, 60923-0535-44, 60923-0536-45, 60923-0537-46, 60923-0538-47, 60923-0539-48, 60923-0540-49, 60923-0541-50, 60923-0542-51, 60923-0543-52, 60923-0544-53, 60923-0545-54, 60923-0546-55, 60923-0547-56, 60923-0548-57, 60923-0549-58, 60923-0550-59, 60923-0551-60, 60923-0552-61, 60923-0553-62, 60923-0554-63, 60923-0555-64, 60923-0556-65, 60923-0557-66, 60923-0558-67,**	**J3490, J3590**

Drug Name	NDC Code	HCPCS Code (if Applicable)
	60923-0559-68, 60923-0560-69, 60923-0561-70	
Eloctate	71104-0801-01, 71104-0802-01, 71104-0803-01, 71104-0805-01, 71104-0806-01;71104-0807-01 71104-0808-01, 71104-0809-01, 71104-0810-01	J7205
Evkeeza	61755-0010-01, 61755-0013-01	J1305
Gattex	68875-0101-01, 68875-0102-01 , 68875-0103-01	J3490
Givlaari	71336-1001-01	J0223
Haegarda	63833-0828-02, 63833-0829-02	J0599
Hemgenix	00053-0099-01, 00053-0100-10, 00053-0110-11, 00053-0120-12, 00053-0130-13, 00053-0140-14 , 00053-0150-15, 00053-0160-16, 00053-0170-17, 00053-0180-18, 00053-0190-19, 00053-0200-20, 00053-0210-21, 00053-0220-22, 00053-0230-23, 00053-0240-24, 00053-0250-25, 00053-0260-26, 00053-0270-27, 00053-0280-28, 00053-0290-29, 00053-0300-30, 00053-0310-31, 00053-0320-32, 00053-0330-33 , 00053-0340-34, 00053-0350-35, 00053-0360-36, 00053-0370-37, 00053-0380-38, 00053-0390-39, 00053-0400-40, 00053-0410-41, 00053-0420-42, 00053-0430-43, 00053-0440-44, 00053-0450-45, 00053-0460-46, 00053-0470-47, 00053-0480-48	J1411
Joenja	71274-0170-60	J8499
Kimmtrak	80446-0401-01	J9274
Krystexxa	75987-0080-10	J2507
Lamzede	10122-0180-02, 10122-0180-05,10122-0180-10	J3490, J3590
Livmarli	79378-0110-01	J8499
Myalept	76431-0210-01	J3490, J3590
Nexviazyme	58468-0426-01	J0219
Novoseven	00169-7201-01, 00169-7202-01, 00169-7205-01, 00169-7208-01, 00169-7211-11, 00169-7212-11 , 00169-7215-11, 00169-7218-11	J7189
Nulibry	73129-0001-01	J3490
Olpruva	72542-0002-01, 72542-0200-02, 72542-0200-09, 72542-0003-01, 72542-0300-02, 72542-0300-09, 72542-0400-02, 72542-0400-18,	J8499

Drug Name	NDC Code	HCPCS Code (if Applicable)
	72542-0500-02, 72542-0500-18, 72542-0600-02, 72542-0600-18, 72542-0367-01, 72542-0667-02, 72542-0667-18	
Orladeyo	72769-0101-01, 72769-0102-01	J8499
Oxlumo	71336-1002-01	J0224
Procysbi	75987-0101-08	J8499
Ravicti	75987-0050-06	J8499
Rethymic	72359-0001-01	J3590
Revcovi	57665-0002-01	J3590, J3490
Roctavian	68135-0927-01, 68135-0927-48	J3490, J3590
Ryplazim	70573-0099-01, 70573-0099-02	J2998
Skysona	73554-2111-01	J3590
Soliris	25682-0001-01	J1300
Spinraza	64406-0058-01	J2326
Takhzyro	47783-0644-01	J0593
Viltepso	73292-0011-01	J1427
Vimizim	68135-0100-01	J1322
Vyjuvek	82194-0510-02	J3590
Vyondys 53	60923-0465-02	J1429
Xenpozyme	58468-0050-01	J0218
Xyntha	58394-0016-03,58394-0022-03, 58394-0023-03, 58394-0024-03, 58394-0025-03, 58394-0012-01, 58394-0013-01, 58394-0014-01, 58394-0015-01	J7185
Zolgensma	71894-0120-02, 71894-0121-03,71894-0122-03, 71894-0123-03, 71894-0124-04, 71894-0125-04, 71894-0126-04, 71894-0127-05, 71894-0128-05, 71894-0129-05, 71894-0130-06, 71894-0131-06, 71894-0132-06, 71894-0133-07,71894-0134-07, 71894-0135-07, 71894-0136-08, 71894-0137-08, 71894-0138-08, 71894-0139-09, 71894-0140-09, 71894-0141-09	J3399
Zynteglo	73554-3111-01	J3590

HEPATITIS C RISK POOL REIMBURSEMENT METHOD

MDH is continuing to pay for Hepatitis C treatments in the capitation rates while controlling for differences in treatment volume across MCOs with a modification for calendar year 2024. The method eliminates the previous Hepatitis C case rate and instead funds Hepatitis C by including the expenses in the capitation rating cohorts. After the contract period has ended, the Hepatitis C prescriptions provided by MCO will be compared to the amount funded via the capitation rates, and a risk pool will be calculated to protect MCOs from adverse selection. The key aspects of the risk pool are:

1. The risk pool will not be budget neutral, meaning that MDH will add/remove dollars to the initial Hepatitis C funding provided via the capitation rates
2. The cost per prescription used in developing the capitation rates will be adjusted via a risk corridor based on the actual cost per prescription for the MCO.
    a. The risk corridor is two-sided with a band of +/- 2%.
    b. If the amount in capitation for claims is insufficient, MDH will make a payment to the MCO.
    c. If the amount in capitation for claims exceeds cost, the MCO will make a payment to MDH.
    d. Claims costs are measured after incorporating drug rebates.
3. The MCO's adjusted cost per prescription will be multiplied by the number of prescriptions provided by the MCO to calculate a floor or ceiling cost.
4. The floor or ceiling cost will be compared to the funding received via the capitation rates based on the MCO-specific membership distribution.
5. The difference between actual funding and floor or ceiling cost will be paid to or recouped from the MCOs, respectively.
6. All steps above exclude administration both on the cost side as well as the funding received in the capitation rates.

CMS INTEROPERABILITY AND PATIENT ACCESS FINAL RULE REQUIREMENTS

The Centers for Medicare and Medicaid Services (CMS) Interoperability and Patient Access Final Rule (CMS-9115-F) focuses on driving interoperability and patient access to health information by facilitating the free and secure flow of data. CMS partnered with the Office of the National Coordinator (ONC) for Health Information Technology to identify Health Level 7 ® (HL7) Fast Healthcare Interoperability Services ® (FHIR) Release 4.0.1 as the foundational standard to support data exchange via secure application programming interfaces (APIs). Additionally, CMS is adopting the standards for FHIR-based APIs finalized by Health and Human Services (HHS) in the ONC 21st Century Cures Rule at 45 CFR 170.215.

The CMS Interoperability Rule requires each Medicaid Managed Care Organization (MCO) to establish, based upon the standards finalized in the ONC 21st Century Cures Rule (45 CFR 170.213 & 215): (I) Patient Access API (42 CFR 438.242(b)(5)); (II) Provider Directory API (42 CFR 438.242(b)(6)); (III) Payer to Payer Data Exchange (42 CFR 438.62(b)(1)(vi)). Each MCO must implement and maintain a secure, HL7 FHIR Release 4.0.1 standards-based API. The Provider Directory and Patient Access APIs are required to be implemented by January 1, 2021. However, due to COVID-19, CMS will not enforce these new requirements until July 1, 2021. Payers must implement a process for the payer-to-payer data exchange when CMS establishes a new compliance date.

I. **Patient Access API.** To allow patients to easily access their claims information, including cost, as well as a defined subset of clinical information.
II. **Provider Directory API.** To avail a searchable public provider directory displaying certain information. Provider directory information must be accessible and searchable via a standards-based API.
III. **Payer-to-Payer Data Exchange.** To enable the exchange of certain patient clinical data (i.e., the U.S. Core Data for Interoperability [USCDI] version 1 data set), at the patient's request, between payers allowing patients to create a cumulative health record that moves across payers.

CMS requires that the implementation of the above APIs is supplemented with additional components, such as an educational page for patients about sharing their health information with third parties. For these requirements, MCOs should refer to the Final Rule, located here: https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

HEALTHCHOICE POPULATION HEALTH INCENTIVE PROGRAM

Effective January 1, 2022, MDH established the HealthChoice Population Health Incentive Program (PHIP).

Performance Measures and Funding

An MCO may be eligible for an incentive payment for the following performance measures:

1) Ambulatory care visits for Supplemental Security Income (SSI) adults
2) Ambulatory care visits for Supplemental Security Income (SSI) children
3) HEDIS asthma medication ratio
4) HEDIS hemoglobin A1c control for patients with diabetes—poor control (>9.0%)
5) Lead screening measures:
    (a) Lead screening measure for children 12-23 months old
    (b) HEDIS lead screening in children
6) HEDIS postpartum care
7) HEDIS risk of continued opioid use—≥31 days covered
8) HEDIS timeliness of prenatal care

Each measure identified shall be valued equally at a proportional share of available incentive funds, except for measures (5)(a) and (b), which are each valued at half of the available incentive funds relative to one of the other measures.

There shall be two rounds of potential incentive payments an MCO may earn. Total PHIP funding shall be determined prior to the measurement year and included in the MCO contract. (For MY 2024, PHIP will be funded at 0.5% of HealthChoice total capitation for the measurement year, based on funds available in MDH's FY 2024 and FY 2025 budgets.) All PHIP payments shall be funded independently from and outside of MCO capitation payments during a given calendar year.

Each MCO shall be eligible for no more than 1 percent of the plan's measurement year capitation payments, excluding supplemental payments outside of capitation, as total payment from Round One and Round Two. Result findings and the determination of PHIP incentive payments are not subject to appeal pursuant to COMAR 10.67.10.02B.

If MDH determines that the score for any measure may not be comparable due to alterations in measure specifications or other factors, MDH may exclude the measure from the PHIP and adjust the incentive valuation in accordance with the remaining performance measures.

Round One Incentives

An MCO may earn two types of incentives in Round One:

1) A performance incentive payment; and
2) An improvement incentive payment.

If an MCO does not report a performance measure or an MCO has a performance score of zero percent, then the MCO is awarded no performance or improvement incentive payments for this measure.

Round One Performance Incentive Payments

Performance incentive payments for Round One shall be based on the following categories for each performance measure:

1) Superlative performance, meaning the performance measure's score is at or above the 90th percentile of national HEDIS Medicaid HMO performance during the measurement year, or estimated 90th percentile among Maryland HealthChoice MCO performance for non-HEDIS performance measures.
2) Very strong performance, meaning the performance measure's score is between the 75th to 89th percentiles of national HEDIS Medicaid HMO performance during the measurement year, or between the estimated 75th to 89th percentiles among Maryland HealthChoice MCO performance for non-HEDIS performance measures.
3) Strong performance, meaning the performance measure's score is between the 50th to 74th percentiles of national HEDIS Medicaid HMO performance during the measurement year, or between the estimated 50th to 74th percentiles among Maryland HealthChoice MCO performance for non-HEDIS performance measures.

Payments for Round One performance incentives shall be allocated as follows:

1) For superlative performance, an MCO may earn 100 percent of the incentive allocation for the performance measure.
2) For very strong performance, an MCO may earn 66.6 percent of the incentive allocation for the performance measure.
3) For strong performance, an MCO may earn 33.3 percent of the incentive allocation for the performance measure.

Any MCO earning a performance measure score below the 50th percentile of national HEDIS Medicaid HMO performance during the measurement year on a HEDIS-based measure, or below the calculated 50th percentile among Maryland HealthChoice MCO performance for a non-HEDIS measure, shall be ineligible for a Round One performance incentive payment.

Round One Improvement Incentive Payments

An MCO may earn an improvement incentive payment of 33.3 percent of the incentive allocation for any performance measure if the following conditions are met:

1) The MCO demonstrates improvement of at least 0.5 percentage points in the measure compared to the previous measurement year, and
2) The performance measure score is at or above the 50th percentile of national HEDIS Medicaid HMO performance on a HEDIS-based measure, or the 50th percentile of Maryland HealthChoice MCO performance for a non-HEDIS measure.

Please note:

- An MCO earning a superlative performance incentive payment for a performance measure is ineligible for an improvement incentive payment for the same measure.
- For any performance measures in which a lower score indicates stronger performance, year-over-year improvement is demonstrated by a reduction in the score for that measure.
- If an MCO is missing or zero-valued for a performance measure in the previous year, then no improvement incentive will be awarded in the measurement year.

Round Two Incentives

An MCO may qualify for payments under Round Two if the following conditions are met:

1) The MCO earned above 80 percent of possible Round One incentives.
2) The MCO did not have sanctions applied during the measurement year for failure to meet the HEDIS MCO Performance Monitoring Policies included in the MCO agreement.

Any remaining funds that were unallocated during Round One may be awarded to eligible MCOs in Round Two for a maximum incentive award of up to 1 percent of its total capitation payment during the PHIP measurement year, excluding supplemental payments outside of capitation. If any remaining funds that were unallocated during Round One are not sufficient to settle all qualifying MCOs up to 1 percent of capitation in Round Two, then the leftover funds will be awarded proportionally among qualifying MCOs based on enrollment.

If additional funds remain after both Round One and Round Two, MDH may, within its discretion, allocate the funding as follows:

1) Make additional payments to MCOs that are below 1 percent of capitation based on improvement or performance, or
2) Place remaining funds into a non-lapsing pool, subject to approval by the Maryland Department of Budget and Management.

For reporting purposes only, MDH may stratify the PHIP measures to review for health equity.

HEALTHCHOICE HEALTH EQUITY INCENTIVE METHODOLOGY

In order to provide additional resources to MCOs with populations potentially subject to health inequities, MDH established a health equity methodology that allocates a defined amount of funding annually to MCOs based on the county of residence of their members. This methodology will be effective as of January 1, 2024.

Under this methodology, each MCO will receive a proportion of available funding based on the number of members residing in jurisdictions with the highest levels of social disadvantage. The Health Equity Incentive Program is established in accordance with regulations at 42 CFR 438.6. This methodology involves two steps: 1) develop the HealthChoice socioeconomic disadvantage index (SDI) and 2) allocate funding to MCOs based on this index.

For CY 2024, a total of $8 million is allocated for this incentive across the Maryland HealthChoice Program. The incentive amount your MCO will receive for CY 2024 is $_____. Payments will be disbursed twice a year in July and December. Future funding availability is at the discretion of the MDH budget for fiscal years (FY) 2024 and 2025. Index calculations and the determination of incentive amounts are not subject to appeal pursuant to COMAR 10.67.10.02B.

I. Development of the HealthChoice Socioeconomic Disadvantage Index (SDI)

The SDI is intended to a) capture several different domains of socioeconomic disadvantage, thus implying a holistic view of "need"; b) use timely data from high-quality sources; and c) capture meaningful variation in each measure. Each county (including Baltimore City) shall receive an SDI score, which will be used to allocate funding to MCOs.

For CY 2024, the SDI shall consist of sub-measures from four domains: community safety; food security; housing security; and transportation access.

II. Allocating Available Incentive Funding

MDH shall allocate available funding for the Health Equity Incentive to counties with high socio-economic need. For CY 2024, MDH shall define this to be the counties with the top 6 SDI scores. Available funds will be allocated to MCOs based on their proportion of membership of the total HealthChoice membership residing in counties with high socio-economic need.

This selection does not imply that socioeconomic disadvantage observed in other county populations should not merit attention. Rather, it is an acknowledgment that the limited funding initially available may be most impactful if targeted to locations and populations

with the greatest disadvantage or need. The rankings may be refreshed as data sources are updated to reflect changes over time in area-level disadvantage and to accommodate new measures as determined by MDH.

HEALTHCHOICE ENCOUNTER DATA QUALITY POLICY

The following policy outlines requirements for MCO maintenance and reporting of encounter data to MDH.

The MCO must submit encounter data reflecting 100 percent of provider-enrollee encounters in CMS1500 and UB04 format, or alternative formats previously approved by MDH, such as ASC X12N 837 and NCPDP formats and ASC X12N 835 format. The MCO must submit encounter data that identifies the provider who delivers any items or services to Enrollees at a frequency and level of detail to be specified by CMS and MDH.

The MCO must report encounter data within 60 calendar days after receipt of the claim from the provider and utilize a secure online data transfer system.

The MCO is responsible for having a formal monitoring and reporting system to reconcile submission and resubmission of encounter data to MDH to ensure timeliness of submissions, resubmissions, and corrections to ensure the overall completeness and accuracy of encounter data.

The MCO's responsibility includes a formal monitoring and reporting system to reconcile submissions and resubmissions of encounter data between the MCO and subcontractors, providers, or other entities for all covered services under this Agreement.

MDH and MCOs will participate in an encounter data workgroup and collaborate on guidance regarding what information from encounters should be incorporated into the HealthChoice Financial Monitoring Reports (HFMRs). MDH's contracted independent accounting firm will perform procedures to verify that the agreed upon encounter data is excluded from the HFMR.

HEALTHCHOICE AND MARYLAND PRIMARY CARE PROGRAM ALIGNMENT

This policy outlines the requirements for MCOs participating in HealthChoice with regard to designing and implementing an advanced primary care program that aligns with the principles of the Maryland Primary Care Program (MDPCP).

I. Program Design

MCOs will participate in design meetings with MDH and other entities, as needed, to support the development of the aligned advanced primary care program, including but not limited to the finalization of the following program components, pending approval by the Center for Medicare and Medicaid Innovation (CMMI):

- Payment model(s) for care transformation and quality
- Quality measures and equity
- Provider eligibility and attribution
- Care management and engagement strategy
- Standardized data-sharing platform housed in CRISP
- Aligned FQHC program

II. Eligibility, Participation, and Attribution

Pending finalization of program design, MCOs will utilize CY 2024 to offer the aligned program to eligible providers in their networks and negotiate contracts for implementation in CY 2025. For providers that accept the offer, contracts must be finalized prior to January 1, 2025. MCOs will provide participating providers with information on members who are attributed to these practices, following execution of the respective provider contracts.

HEALTHCHOICE IN-LIEU-OF SERVICES AND SETTINGS

An "In-Lieu-Of Service or Setting" (ILOS) means a medically appropriate, cost-effective substitute for a covered service or setting under the State Plan. An Enrollee is not required to use the alternative service or setting. Any ILOS is subject to MDH and CMS approval.

ILOS is governed by six principles that must be satisfied for CMS approval:

1. ILOSs must advance the objectives of the Medicaid program.
    a. ILOSs must not violate any applicable federal requirements, including 42 CFR 438.3(e)(2), general prohibitions on payment for room and board costs under title XIX of the Social Security Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Emergency Medical Treatment and Labor Act.
    b. ILOSs must be approvable through a state plan amendment authorized through the Social Security Act.
2. ILOSs must be cost effective.
    a. For a managed care program, the ILOS cost percentage should not exceed five (5) percent.
    b. The ILOS cost percentage is a calculation of the portion of the total capitation payments attributable to all ILOSs for the managed care program (numerator) divided by the total costs for the specific managed care program that includes all capitation payments, state directed payments, and pass-through payments (denominator). This calculation requires actuarial certification to be submitted with the managed care capitation rate certification.
3. ILOSs must be medically appropriate.
    a. For any ILOS, the HealthChoice MCO Agreement must include at a minimum:
        i. The name and definition of each ILOS, and the covered Medicaid State Plan services or settings for which they substitute;
        ii. The coding to be used on claims and encounter data to identify ILOS;
        iii. The clinically oriented deifnitions for the target populations for which MDH has determined each ILOS to be a medically appropriate and cost effective substitute; and
        iv. The method the MCO uses to ensure that the provider uses their professional judgment to determine and document that the ILOS is medically appropriate for the specific Enrollee, based on the defined target population.
    b. MDH may impose additional provider qualifications, limitations, or protocols to ensure ILOS are medically appropriate and cost effective.
4. ILOSs must be provided in a manner that preserves enrollee rights and protections.
    a. MCOs must not require Enrollees to use available ILOSs.

b. MCOs must not deny Enrollees access to Medicaid State Plan services or settings on the basis that an Enrollee has been offered and ILOS, is currently receiving an ILOS, or has received an ILOS in the past.
c. All appeal and grievance rights and procedures apply to provision and denial of ILOS.

5. ILOSs must be subject to appropriate monitoring and oversight.
    a. MDH is responsible for providing an actuarial report for the ILOS Cost Percentage for the HealthChoice program.
    b. MDH is responsible for notifying CMS in writing within 30 days of determining an ILOS is no longer a medically appropriate or cost effective substitute, or if MDH determines any other areas of non-compliance such as failure to protect enrollee rights.
        i. If CMS determines the ILOS should be terminated, a transition of care policy is required to phase out the ILOS.
        ii. The transition of care process should not exceed 12 months from the date of the rescission notice from CMS. Enrollees must be notified that the ILOS they are receiving is being terminated as expeditiously as required by the Enrollee's health conditions.
        iii. The HealthChoice MCO Agreement will also be amended to remove the ILOS, along with rate certifications as necessary.
    c. MDH must attest to audit encounter, grievance, appeals, and state fair hearing data to ensure accuracy, completeness, and timeliness.
        i. MDH must also stratify encounter data about ILOS by sex, sexual orientation, gender identity, race, ethnicity, disability status, and language spoken to inform health equity initiatives and efforts to mitigate health disparities.
        ii. The above stratification must be part of the audited data to evaluate the medical appropriateness and cost effectiveness of each ILOS continually.
    d. MDH must document for CMS how the utilization and cost of an ILOS, as well as any savings resulting from the use of an ILOS, were considered in the development of the actuarially sound capitation rates, and include this information in the rate certification.
6. ILOSs must be subject to retrospective evaluation, when applicable.
    a. If the ILOS Cost Percentage exceeds one point five (1.5) percent, MDH must submit a retrospective evaluation that includes ILOSs to determine their overla impact on furthering the purposes of the Medicaid program. The evaluation must include, at a minimum:
        i. Impact of each ILOS on the utilization of State Plan-covered services or settings, including associated cost savings, trends in MCO and Enrollee use of each ILOS, and impact of each ILOS on quality of care;