Calendar Year 2025

HealthChoice Managed Care Organization Agreement

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HEALTHCHOICE MANAGED CARE ORGANIZATION AGREEMENT

THIS AGREEMENT (Agreement), effective January 1, 2025, 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. "AHEAD" means States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, a state total cost of care model to drive state and regional health care transformation and multi-payer alignment to improve the total health of a state population and lower costs across all payers.

3. "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.

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

5. "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.

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

7. "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.

8. "Dual Eligible Special Needs Plan" means a Medicare Advantage health plan offering broader Medicare coverage and benefits to individuals who are dually eligible for Medicare and Medicaid benefits.

9. "Encounter Data" means information documenting a service to an Enrollee.

10. "Enrollee" means a Medicaid recipient who is enrolled in a managed care organization.

11. "Extraordinary Personal Event" means an event that includes any of the following:

   A. Leave under the Family Medical Leave Act;

   B. An Incapacitating injury or Incapacitating illness; or

   C. Other circumstances that in the sole discretion of MDH warrant an extended leave of absence, such as extended jury duty or extended military service that precludes the individual from performing their job duties under the Agreement.

12. "Family Medical Leave Act" means a law that allows eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

13. “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.

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

15. "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.

16. “Incapacitating” means any health circumstance that substantially impairs the ability of an individual to perform the job duties described for that individual’s position in the MCO.

17. “Integrated Maternal Health Services initiative” is a grant-funded initiative awarded by the Health Resources and Services Administration that aims to improve rates at which high-risk pregnant and postpartum people are connected to needed services in their communities and to understand the impact of improved use of an integrated system on completed referrals and maternal health outcomes, including maternal mortality in Maryland.

18. “Key Personnel” means all MCO personnel identified in the Agreement as such that are essential to the work being performed under the Agreement.

19. “Maryland Prenatal Risk Assessment” means a form that collects health and other risk information about Medicaid members during their first prenatal care visit. The form’s information is then used to refer pregnant members to services to improve the pregnant person and infant’s health outcomes.

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

21. “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.

22. “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.

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

24. “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.

25. “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.

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

27. “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.

28. “Program” means the Medical Assistance Program.

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

30. "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.

31. “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.

32. “Sudden Vacancy” means an Extraordinary Personal Event, death, resignation, or termination.

33. "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.

34. “State” means the State of Maryland.

35. “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.

36. “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.

37. “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. AHEAD – Advancing All-Payer Health Equity Approaches and Development

3. ASO – Administrative Services Organization

4. CEO – Chief Executive Officer

5. CFO – Chief Financial Officer

6. CIO – Chief Information Officer

7. CMO – Chief Medical Officer

8. CMS – Centers for Medicare and Medicaid Services

9. CoCM – Collaborative Care Model

10. COMAR – Code of Maryland Regulations
11. COO – Chief Operating Officer
12. CQO – Chief Quality Officer
13. CRISP – Chesapeake Regional Information System for our Patients
14. DHHS – U.S. Department of Health and Human Services
15. DPP – Diabetes Prevention Program
16. D-SNP – Dual Eligible Special Needs Plan
17. EMS – Emergency Medical Services
18. EPLS – Excluded Parties List System
19. E&M – Evaluation and Management
20. ePREP – Electronic Provider Revalidation and Enrollment Portal
21. FFS – Fee-for-Service
22. FMLA – Family Medical Leave Act
23. FQHC – Federally Qualified Health Center
24. HEDIS – Healthcare Effectiveness Data and Information Set
25. HSCRC – Health Services Cost Review Commission
26. IMHS – Integrated Maternal Health Services
27. IRO – Independent Review Organization
28. LEIE – List of Excluded Individuals/Entities
29. MCO – Managed Care Organization
30. MHBE – Maryland Health Benefit Exchange
31. MLR – Medical Loss Ratio
32. MPRA – Maryland Prenatal Risk Assessment
33. M-QIP – Maryland Quality Incentive Program
34. NCQA – National Committee for Quality Assurance
35. NDC – National Drug Code
36. NPPES – National Plan and Provider Enumeration System

37. OIGH – Office of the Inspector General for Health
38. PBM – Pharmacy Benefit Manager
39. PHIP – Population Health Incentive Program
40. SSA-DMF – Social Security Administration Death Master File
41. TPL – Third Party Liability
42. TTY/TDD – Teletypewriter/Telecommunication Device for the Deaf
43. URAC – Utilization Review Accreditation Commission
44. 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 T), 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 T).

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 T) 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 T).

5. To submit to MDH, within thirty (30) days of the date the MCO receives information regarding Enrollees, the Medical Assistance Number of the Enrollees, along with the following pertinent information, for any 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.

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 T).

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 T) 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) (Appendix T).

8. To have in place mechanisms to help Enrollees understand the requirements and benefits of the MCO, in accordance with 42 CFR 438.10 and COMAR 10.67.05.01 (Appendix T).

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 T), 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 in accordance with COMAR 10.67.06.26-03 (Appendix T).

G. Standard fertility preservation procedures in connection with gender-affirming treatment, iatrogenic infertility, or medical treatment that may directly or indirectly cause iatrogenic infertility, in accordance with COMAR 10.67.06.30 (Appendix T).

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 and other appropriate Network Providers.

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 are approved by MDH and meet the terms outlined in Appendix R of this Agreement.

L. The Collaborative Care Model (CoCM), in accordance with COMAR 10.67.06.26 (Appendix T).

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 all quality improvement activities listed in COMAR 10.67.04.03B (Appendix T).

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

4. 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).

5. To maintain NCQA accreditation, as set forth in 42 CFR §438.332(b) and COMAR 10.67.03.08 (Appendix T), 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.

6. 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, no later than June 30, 2025.

7. To obtain NCQA Health Equity Accreditation by December 31, 2025, if not already achieved.

8. 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 T) 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 T).

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 T).

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; and

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.

4. To implement the MDH-approved standard screening tool as part of a a coordinated health related social needs assessment and referral strategy, aligned with NCQA's HEDIS Social Need Screening and Intervention measure, and complete the tool with Enrollees on a routine basis to assess social needs that may impact the Enrollee's health outcomes by July 1, 2025.

5. To work in collaboration with MDH to develop data exchanges related to the social needs screening tool with CRISP by December 31, 2025.

6. To agree to collaborate with the Department to implement the requirements of the Consolidated Appropriations Act (CAA) Section 5121 regarding justice-involved youth.

7. To agree to coordinate with MDH and the Department of Human Services to ensure children entering state-supervised care receive an initial health screening within five days of entry.

8. To agree to collaborate with the Department to implement and report on activities related to the Integrated Maternal Health Services (IMHS) initiative, including efforts to improve completion of the Maryland Prenatal Risk Assessment (MPRA), in accordance with Appendix S.

H. **Information Requirements**

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

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 T).

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 T).

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 T).

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 T).

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 T).

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 T).

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, 2025, 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 T).

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

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 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

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

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

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

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

18. To reimburse providers (billed through J codes and CPT codes) for vaccines at the Maryland Medicaid Fee-for-Service rates, at a minimum.

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

20. To participate in the Maryland Quality Incentive Program (MQIP) as described in Appendix J, contingent upon CMS approval.

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

22. To increase reimbursement for insertion and removal of long-acting reversible contraception in accordance with Provider Transmittal 59-24, effective February 15, 2024.

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 based on the Maryland Medicaid MLR Reporting Template Instructions (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 T).

2. To staff the MCO's program integrity efforts in accordance with COMAR 10.67.07.01A(2) (Appendix T).

3. 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.

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

5. 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.

6. 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.

7. 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 T).

8. 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.

9. 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.

10. 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.

11. 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 T).

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

13. 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).

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

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

16. 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).

17. 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.

18. 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.

19. 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.

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

21. 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.

22. To notify a health care provider when retroactively denying reimbursement as a result of coordination of benefits by a carrier that is not an MCO through a written statement providing the name and address of the entity acknowledging responsibility for payment of the denied claim.

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 T).

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 T).

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 T) 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 T).

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 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 over the amount of $50,000 on the MCO;

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

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

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

   F. Overpayments recovered by MDH;

   G. 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 T).

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. Any full or partial withhold of the capitation payment;

   C. Any remittances to MDH related to MLR; or

   D. 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 U.S.C. § 1396a(oo), excluding sections (1)(A)(i)(III) and (B), along with the following drug utilization review requirements from 42 C.F.R. § 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 42 U.S.C. § 1396r-8(k)(2) 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 Md. Code, Ins. § 15-1611.1 and Md. Code, Ins. § 15-1628.3.

E. To require PBMs to comply with the pharmacy audit provisions in accordance with Md. Code, Health-Gen. § 15-103(b)(33) and Md. Code, Ins. § 15-1629 by the end of the Agreement term.

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

G. 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 T), 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, transaction 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 risk mitigation policy (Appendix L-1), Hepatitis C risk pool reimbursement method (Appendix L-2), and moderate-cost high volume drug risk mitigation policy (Appendix L-3).

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. Code, Health-Gen. § 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, Ins.§ 15-858.

17. To provide coverage and reimbursement for all services rendered by a licensed pharmacist within the pharmacist's lawful scope of practice, in accordance with Md. Health-Gen. Art. §§ 15-148, 15-151, and 15-716.

18. To suspend waiver of pharmacy copays to comply with the federal Mental Health Parity and Addiction Equity Act, 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.

Q. **Staffing Requirements**

1. To establish a strategic staffing plan that includes standards for implementing an effective system of health care delivery to Enrollees.

2. To present the staffing plan to MDH for review and approval annually by July 1.

3. To submit to MDH any proposed changes to the staffing plan at least thirty (30) days prior to the anticipated changes taking effect for MDH's review and written approval.

4. To submit an alternative staffing plan to MDH for review and approval if anticipated changes due to a Sudden Vacancy results in a decrease in personnel or impact staff identified as Key Personnel.

5. To employ Key Personnel on a full-time basis (minimum of forty [40] hours a week) to work based in the MCO's office in the state of Maryland for a minimum of two (2) days pers work week, in alignment with the State of Maryland's Telework Policy.

    A. Key Personnel positions bear primary responsibility for the requirements included under the Agreement.

    B. Key Personnel positions may not be split or shared among multiple individuals on an MCO's staff.

    C. Key Personnel may also have shared responsibility for a Maryland-based Dual Eligible Special Needs Plan (D-SNP).

    D. Approval to provide Key Personnel functions for the MCO and for the D-SNP may be subject to change in subsequent contract years based on the size of the D-SNP.

6. To provide to MDH the name, title, qualifications, and contact information of the designated individuals identified to serve in each Key Personnel position.

   A. If a Key Personnel position is vacant, the MCO agrees to provide a staffing plan that includes a timeline for filling the vacant position, as well as a job posting identifying the responsibilities and qualifications required for the vacant position.

7. To share with MDH for review prior to hiring an individual to fill a Key Personnel position, the selected candidate's resume, and allow MDH 14 days to review the resume to determine whether MDH approves the candidate's credentials.

8. To require Key Personnel to work continuously in their role at the MCO for the duration of this Agreement.

9. To require Key Personnel to be dedicated 100% to HealthChoice, except for the Chief Medical Officer (CMO).

10. To submit a substitution request for Key Personnel at least fifteen (15) days prior to the intended change for review and written approval by MDH.

11. To identify a suitable replacement in the event of a Sudden Vacancy of a position identified as Key Personnel or required personnel and provide the same information and items required under Section II.Q.6 of this Agreement to MDH:

    A. Within fifteen (15) days of the actual vacancy occurrence, or

    B. From when the MCO first knew or should have known that the vacancy would be occurring, whichever is earlier.

12. Key Personnel

    A. To identify and maintain Key Personnel to carry out essential functions at the MCO.

    B. To ensure the following Key Personnel positions, at a minimum, are filled at the beginning of this Agreement term:

       i. Chief Executive Officer (CEO), who has authority over all aspects of the MCO's Maryland Medicaid line of business;

       ii. Chief Operating Officer (COO), who is responsible for daily management of all operations and ensuring that performance measures from MDH and CMS requirements are met;

a. The COO may also serve as the primary liaison with MDH for any and all operational issues.

iii. Chief Financial Officer (CFO), who oversees all budgeting and accounting requirements and systems, including participation in HealthChoice capitation rate setting meetings;

iv. Chief Information Officer (CIO), who is responsible for the MCO's Management Information System (MIS) and encounter data oversight;

v. CMO, who provides timely medical advice and consultation as needed, and develops, implements, and interprets medical policies and procedures, including but not limited to service authorizations, claims review, discharge planning, credentialing, referral management, culturally and linguistically appropriate care, and medical review of Grievances and Appeals. Other qualifications are listed below:

a. The CMO must possess a current unrestricted license in Maryland;

b. The CMO must have a minimum of three (3) years of training in a medical specialty and five (5) years of experience providing clinical services;

c. The CMO must be board certified in his/her specialty and actively involved in all major clinical, utilization and quality management decisions of the Contractor;

d. The CMO must have experience and knowledge of evidence-based population management of diverse, low-income populations.

e. The CMO must dedicate a minimum of 75% of their time to HealthChoice and any Maryland D-SNPs.

13. Additional Required Personnel

A. To identify and maintain additional personnel to carry out functions as defined below; the responsibilities of the following personnel shall include, but are not limited to, those listed below:

i. Chief Quality Officer (CQO), who engages and leads the MCO, the MCO's Provider network, as well as delegated Providers in continuous quality improvement activities as defined in Section II.E. of the Agreement and COMAR 10.67.04.03;

ii. The CQO shall be responsible for several tasks regarding the Quality Assessment and Performance Improvement (QAPI) program and Continuous Quality Improvement (CQI) plan;

B. Clinical Operations Manager, who is responsible for designing, administering, and evaluating a unique program of mandatory Case Management and Care Coordination for HealthChoice Enrollees;

i. The Manager shall be an independent licensed clinical social worker, registered nurse, nurse practitioner, and/or physician licensed to practice in Maryland;

ii. This manager shall oversee the provision of a range of targeted, clinical services and benefits in accordance with Section II.D. of the Agreement, COMAR 10.67.04, and COMAR 10.67.06;

C. Appeals and Grievances Manager, or employee with responsibility for overseeing an Enrollee services program that operates twenty-four (24) hours per day, seven (7) days per week, that is capable of:

i. Providing information, answering questions, assisting Enrollees with locating services and maintaining eligibility in a timely fashion;

ii. Resolving Enrollee Grievances; and

iii. Assisting Enrollees to file and pursue Appeals involving the denial, termination or reduction of benefits and services;

D. Provider Relations Manager, or employee who administers a Provider services program that:

i. Furnishes Network Provider support and as applicable, non-Network Provider support;

ii. Serves as an entry point for both network and non-Network Providers that have disputes with the Contractor and wish to participate in the MCO's provider dispute resolution process;

E. Program Integrity Director, who is responsible for:

iii. Developing an effective program to reduce and remediate Provider and beneficiary fraud, waste, and abuse; and

iv. Serving as a liaison to the MOIGH;

F. Chief Compliance Officer, who is responsible for:

i. Developing, implementing, and overseeing policies, procedures, and practices to ensure compliance with the requirements of the contract;

ii. Developing an effective program to reduce and remediate Provider and beneficiary fraud, waste, and abuse.

iii. The Chief Compliance Officer may also serve as the Program Integrity Director;

G. Health Equity Director, who is responsible for establishing and overseeing a comprehensive strategy to advance health equity for enrollees;

i. This role must have authority to direct and manage financial and operational resources and enact activities to operationalize a comprehensive health equity strategy for the MCO;

ii. This role should serve as part of the MCO's senior leadership team;

iii. The individual selected should have demonstrated experience with community health services, working with under-resourced areas and communities of disinvestment, and implementing health equity approaches and models for large organizations, as reflected in their resume;

H. Special Needs Coordinator, who will serve as a point of contact for health care services information and referral for members of special needs populations;

i. This role requires the Coordinator to be skilled in communications and sensitive to the unique needs of the population, their families, guardians, and caregivers;

ii. This role must participate on the MCO’s consumer advisory board, serve as a resource to MCO providers and enrollees, and maintain a record of each denial of treatment and the outcome of the utilization review conducted for

individuals identified as members of special needs populations;

I. Newborn Coordinator, to provide services for a newborn whose mother is enrolled in the MCO on the date of the newborn's birth and who is enrolled or who is auto assigned to the MCO after birth;

i. The role is responsible for researching and confirming the assignment of an eligible newborn to an MCO, working closely with enrollment agents, handling retroactive PCP enrollments, and resolving claims for services provided to newborns;

ii. The role requires the Newborn Coordinator to provide guidance to healthcare providers on newborn-related matters, coordinating with ancillary care providers, and authorizing in-network or out-of-network care as necessary;

J. Marketing Director, to fulfill the marketing requirements outlined in COMAR 10.67.04.23, along with any other policies developed by MDH.

14. To fill all Key Personnel positions by January 1, 2025, and fill all additional required personnel positions by July 1, 2025. The MCO not meeting this requirement may be subject to financial sanctions in accordance with the HealthChoice Financial Sanction Policy in Appendix I of this Agreement.

15. To fill any Key Personnel and additional required personnel positions vacated during the term of this Agreement within sixty (60) days.

16. To agree if a Key Personnel position becomes vacant during the calendar year and remains vacant for more than sixty (60) days, the MCO may be subject to financial sanctions in accordance with the HealthChoice Financial Sanction Policy in Appendix I of this Agreement.

17. To agree to implement staffing guidelines for Additional Required Personnel to be developed and issued by MDH during the Agreement term.

I. 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 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.

5. 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.

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

7. 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 T). 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 T).

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

II. 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, 2025, and terminate on December 31, 2025.

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 T).

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 T); 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 2025 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

APPENDIX A
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 in a separate agreement (the "Underlying Agreement") dated _____, 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. In the event of any Breach, regardless of which party is responsible, Business Associate will provide, within 30 days after the discovery of the Breach a proposed Breach Notification Report to be submitted to HHS Office of Civil Rights (OCR), as required by 45 CFR § 164.408(a).

1. Business Associate and Covered Entity, through its Privacy Officer or their designee, shall cooperate and determine which party will be responsible for filing the Breach Notification Report with OCR and Business Associate shall obtain a written acknowledgment from Covered Entity that assigns this responsibility to either Covered Entity or Business Associate.

2. If Business Associate is assigned the responsibility of filing the Breach Notification Report with OCR, Business Associate shall seek and receive written approval from Covered Entity of the Breach Notification Report prior to it being filed with OCR.

3. Written approval from Covered Entity pursuant to this paragraph shall be from the MDH Privacy Officer or their designee.

I. In the event of any Breach in which 500 or more individuals of any state or jurisdiction are affected, regardless of which party is responsible, the following provisions will apply, as required by 45 CFR §164.406(a):

1. Covered Entity, through its Private Office or their designee, shall determine, in consultation with Business Associate, which party will be responsible for notifying the media, and shall inform Business associate in writing as to its determination.

2. If Business Associate is assigned the role of notifying the media, Business Associate shall seek written approval from Covered Entity as to the content of any notification to be made to the media prior to any media outlet being notified of the breach and shall incorporate any language suggested by Covered Entity.

3. If assigned responsibility, Business Associate shall provide its proposed media notification to Covered Entity for review within thirty (30) days of the date of discovery of the breach.

4. Written approval from Covered Entity pursuant to this paragraph shall be from the MDH Privacy Officer or their designee.

5. If Covered Entity assigns the responsibility to itself, it will inform Business Associate in writing as to this determination and will offer Business Associate the opportunity to review the notification before its disseminated.

J. 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;

K. 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;

L. 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;

M. 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;

N. 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);

O. 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.

P. 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:

By: _____

Name: Ryan B. Moran

Title: Deputy Secretary of Health Care Financing and Medicaid Director

Date: _____

BUSINESS ASSOCIATE:

By: _____

Name: _____

Title: _____

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.

Incident Specific Questions:

1. Please provide a brief description of the incident, including what type of information was disclosed or accessed, who received the information and the manner in which it was accessed or disclosed. Also include the names and contact information for all individuals involved:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. If you believe this incident was inadvertent, accidental or unintentional, please provide any information you have to support that determination:

_____

_____

_____

_____

3. Was the information viewed or actually retained by someone who should not have the information? If so, please explain:

_____

_____

_____

_____

4. What type of identifying information (e.g. names, SSN, medical record number etc.) was acquired, accessed, or disclosed?

_____

_____

_____

_____

5. If available, please provide any information you have about the person or entity that received the information:

_____ _____

_____

_____

_____

6. What steps, if any, have been taken to contain or mitigate the incident? Please provide as much descriptive information as possible:

_____

_____

_____

_____

_____

_____

_____

Additional Incident Details:

Date incident occurred: _____ Date incident was discovered: _____

Estimate number of individuals affected by the breach: _____

Type of incident (e.g. loss, theft, improper disposal, unauthorized access, hacking):

_____

_____

Location of information breach (e.g. laptop, desktop, email, paper files etc.):

_____

_____

Type of information involved (e.g. demographic, financial, clinical):

_____

_____

Safeguards that were in place prior to the breach (e.g. firewalls, encryptions, locks, training):

_____

_____

Please provide any other information you have or believe may be helpful in investigating or resolving this incident. If you wish to include any attachments to this form, please describe the attachments here:

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

Name

_____

Date

_____

Signature

Please send this form by email to the MDH Privacy Officer - mdh.privacyofficer@maryland.gov

APPENDIX B
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: _____

APPENDIX C
MANAGED CARE ORGANIZATION REIMBURSEMENT

This agreement to establish new reimbursement rates is made this _____day of _____, 2024, 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, 2025.

1. MCO agrees to accept the reimbursement rates set forth in Appendix C, effective January 1, 2025.

2. MDH agrees to reimburse MCO at the rates set forth in Appendix C, effective January 1, 2025.

II. Mid-Year Acuity Adjustment for Calendar Year 2025

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 2025:

1. MDH agrees to account for additional procedural disenrollment that occurs after April 30, 2024. MDH agrees to use the MedicaidRx risk scores corresponding to those additional members that are disenrolled as procedural disenrollment during the mid-year acuity update.

2. The CY25 mid-year acuity adjustment methodology will not require additional risk scores to be calculated, since the risk scores for all members captured in the CY22 base data were calculated when setting the original CY25 rates.

3. MCO agrees to accept the mid-year acuity adjustment methodology set forth in this Appendix C, effective January 1, 2025.

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, 2025.

III. Mid-Year Rate Re-Opening for Calendar Year 2025

WHEREAS, in response to ending the Public Health Emergency for Covid-19 and the subsequent continued disenrollment and its impact on the Maryland Medicaid Managed Care

Program, MDH has established the following mid-year rate re-opening methodology for calendar year 2025 that would revisit the following adjustments:

5. Risk adjustment;

6. Trend;

7. Administration;

8. Regional factors; and

9. Relational modeling.

To assist with the assessment, the MCOs will provide additional data to MDH, including detailed claims data as well as a year-to-date HFMR for calendar year 2025.

IV. HealthChoice Maternal and Child Health Initiative Risk Corridor for Calendar Year 2025

1. The 2025 risk corridor will include target medical expenditures for the MCO of $0.52 PMPM.

2. No reconciliation will occur for expenditures within a +/- 10% corridor of the target, or between $0.47 and $0.57.

3. For expenditures below $0.47, the MCO must make a payment back to MDH in the amount below $0.47 multiplied by enrollment.

4. For expenditures above $0.57, MDH must make a payment to the MCO in the amount above $0.57 multiplied by enrollment.

[INSERT RATE TABLE]

[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
_____	_____

APPENDIX D
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 return to being sourced from the NCQA national HEDIS Medicaid HMO means and percentiles for the prior measurement year, beginning with HEDIS Measurement Year 2024 and going forward. Performance monitoring comparisons for HEDIS Measurement Year 2021 and prior years were based on the NCQA national HEDIS Medicaid HMO means and percentiles from the prior HEDIS measurement year. Performance monitoring comparisons for HEDIS Measurement Years 2022 and 2023 were based on the NCQA national HEDIS Medicaid HMO means and percentiles from the same 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
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. The minimum compliance score for each area is 80%.

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, 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 during calendar year 2025.

Part 1. Enforcement Guidelines – Minor Problems

	MCO Network Adequacy	HEDIS Performance	EPSDT/ Healthy Kids Review	Systems Performance Review (SPR)	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. - Financial sanctions other than enrollment freeze. - 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 to freezing auto-assignments, freezing voluntary assignments, or financial sanctions.	- 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.

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. - 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	- 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. - Freeze voluntary enrollment in areas of the state as determined by MDH. - Financial sanctions other	- 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 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.	- 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 to freezing auto-assignments,	- Written CAP to address improvement of project plan to increase the confidence level. - Continuation of project until permitted to sunset by MDH.

	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.	than enrollment freeze. - Contract termination and MCO closure in all counties.		freezing voluntary assignments, or financial sanctions. - Application of financial sanctions.	

APPENDIX E
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 _____, 2024, 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, 2025, 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, 2025, 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

Please complete each field below in detail. The MCO is committing to offering the optional benefits identified below for the entire period of this Agreement.

Benefit *Include description of the benefit*	**Population** *What age group is this benefit available for?*	**Limitations (if applicable)** *Include any quantity limits, maximum allowances, etc.*

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
_____	_____

APPENDIX F
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

[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.

Pediatric Sub-Specialties (Cardiology, Gastroenterology, Neurology, Surgery)	30	15	80	60	250	200

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 the duration of the 2025 HealthChoice MCO Agreement, services from doulas are considered self-referred, so long as the doula is actively enrolled in Maryland Medicaid. MCOs are encouraged to continue adding doulas as network providers to meet the network adequacy standards below.

b. For urban areas (Baltimore City), MCOs are required to have a minimum of four doulas.
c. 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.
d. 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.
e. 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.
f. 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.

APPENDIX G

Maryland Medicaid Medical Loss Ratio (MLR) Reporting Template Instructions

PURPOSE AND OBJECTIVE

The purpose of these instructions is to define the annual financial reporting requirements for the Medical Loss Ratio (MLR) Reporting Template based on the contract with the State of Maryland (State), the Department of Health (Department), to provide services to members of the State's Medicaid managed care program. These instructions are intended to establish consistent and uniform reporting by all health plans.

The MLR Reporting Template is to be completed and submitted to the Department by the due date outlined within these instructions. The health plan shall submit the MLR Reporting Template without alteration, unless directed otherwise by the Department.

Input fields for the MLR Reporting Template are shaded in light yellow. Unanswered questions or blank lines throughout the MLR Reporting Template will render it incomplete and may result in a resubmission request. If no answers or entries are appropriate, enter "Not Applicable (N/A)" or "0" in the input field. Any resubmission must have prior Department approval of the special circumstances.

The health plan must use comments, explanations, and notes any time it is necessary to provide further explanation in support of information reflected within the MLR Reporting Template.

Unless noted otherwise, Generally Accepted Accounting Principles (GAAP) are to be used in the preparation of the MLR Reporting Template. All revenues and expenses are to be reported using the accrual basis of accounting. The accrual basis of accounting recognizes revenue when it is earned and expenses in the period incurred, without regard to the time of receipt or payment of cash.

Any line heading with the description of "Reserved" should be left blank. These lines will be used for future reporting, if necessary.

References throughout the instructions are included for proper citation of guidance. The referencing is related to the MLR reporting, and references are noted within each applicable section.

- The Medicaid and Children's Health Insurance Program (CHIP) rule (CMS-2390-F), published on May 6, 2016 requires all Medicaid and CHIP managed care programs ensure, through contracts for rating periods starting on or after

July 1, 2017, that each health plan calculates and submits an MLR in accordance with 42 Code of Federal Regulations (CFR) § 438.8.

- The Medicaid Program: Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality rule (CMS-2439-F), published on May 10, 2024.

These instructions will be periodically reviewed by the Department to evaluate its applicability to the present circumstances and to recommend changes. The Department may seek input from the health plans, auditors, and actuaries during the review. Any necessary changes will be implemented prior to the new calendar year.

Documentation is necessary to adequately support the reported data per 42 CFR § 438.604. While supporting documentation is not required at the time of the MLR Reporting Template submission, it should be readily available and must be provided upon request for periodic audits in accordance with the requirements of 42 CFR § 438.602(e) unless otherwise requested by the Department.

Per 42 CFR § 438.3(u), health plans and subcontractors, as applicable, are required to retain records for a period of no less than 10 years.

Require any third-party vendor providing services to enrollees to supply all underlying data to that health plan within 180 days of the end of the MLR reporting period or within 30 days of being requested by the health plan, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting per 42 CFR § 438.8(k)(3).

WORKSHEET 1 – OVERVIEW

The Overview tab contains links to all tabs within the Reporting Template Contents, Entity, and Reporting Period tables.

Entity

Input requested health plan information as required.

Per 42 CFR § 438.8(k)(xii), the health plan's aggregation method description for all Medicaid and CHIP populations covered under the contract with the State is required.

Within the input field outline health plan specifics.

42 CFR § 438.8(k)(xii) A description of the aggregation method used under paragraph (i) of this section.

Reporting Period

The MLR Reporting Template captures data on a calendar year (CY) reporting period.

The table below defines the MLR reporting period, based on dates of service (incurred from/through), paid through date, and submission due date.

If the template submission due date is a non-business day, submit on the following business day.

Reporting Period	Incurred From	Incurred Through	Paid Through Date	Template Due Date
Annual (CY)	January 1	December 31	June 30	September 1

WORKSHEET 2 – MLR CALCULATION

The health plan must submit to the Department a report which complies with the requirements concerning premium revenue received and expenses related to Maryland Medicaid enrollees [42 CFR § 438.8(a)]. A June 30 paid through date is required for the annual MLR calculation.

In 42 CFR § 438.4(b)(9), CMS requires the MLR for health plans as calculated and reported under 42 CFR § 438.8 be used in the development of actuarially-sound capitation rates effective for rating periods starting on or after July 1, 2017. The MLR is used to assess whether capitation rates are appropriately set by generally illustrating how these funds are spent on incurred claims and health care quality improvement (HCQI)/health information technology (HIT)/external quality review (EQR) as compared to administrative expenses. The MLR also demonstrates adequate amounts under the capitation payments are spent on services for enrollees.

Incurred Claims Expenditures

All claims are to be reported based on date of service, including a paid through period of six months.

Claims Paid (Non Subcapitated) – Direct claims that the health plan paid to providers for services or supplies covered under the contract. Health care expenses are to be reported net of third party liability (TPL) and coordination of benefits (COB).

42 CFR § 438.8(e)(2) Incurred claims.

(i) Incurred claims must include the following:

(A) Direct claims that the MCO paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees.

Claims Paid (Subcapitated) – Total amounts paid to the providers for each vendor or capitated provider for the dates of service in the MLR reporting period. Any differences related to the per-member per- month (PMPM) compared to the actual amounts paid to providers should be captured in Non-Claims Costs. All arrangements that are not claim based should be reported within the

subcapitated section, including vendors paid based on an invoiced amount. Pharmacy claims should be reflected as the amounts paid to pharmacies.

- Ensure third party capitated providers (directly providing services to enrollees) are also captured within the MLR Reporting Template. If there are capitated providers, the amount should be reported at the cost of the entity performing the services, to separate the direct provision of covered services from administrative costs. See below for additional clarifications.

Per May 15, 2019 the CMCS Information Bulletin (guidance specific to the Medicaid MLR)

An exception to the general approach applies when a subcontractor, through its own employees, provides Medicaid covered services directly to enrollees. In this circumstance, the entire portion of the amount the Medicaid managed care plan pays to the third-party vendor that is attributable to the third- party vendor's direct provision of Medicaid covered services should be included in incurred claims, even if such amount includes reimbursement for the third-party vendor's own administrative costs related to the direct provision of Medicaid covered services. The phrase "through its own employees" does not include a subcontractor's contracted network of providers because such network providers are not considered employees of the third-party vendor. Additionally, when the subcontractor is also performing an administrative function not attributable to its direct provision of Medicaid covered services, such as eligibility and coverage verification, claims processing, utilization review, or network development, payment by the managed care plan to the subcontractor for such functions are a non-claims administrative expense as described in 42 CFR § 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations.

42 CFR § 438.8(e)(2) Incurred claims.

(v) Amounts to be excluded from incurred claims:

(A) *Non-claims costs, as defined in paragraph (b) of this section, which include the following:*

(1) *Amounts paid to third party vendors for secondary network savings.*

(2) *Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.*

(3) *Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.*

IBNR Estimates (Non Subcapitated) – Unpaid claims liabilities for the MLR reporting period, including claims reported that are in the process of being adjusted. This should exclude any margin calculated with total reserves.

42 CFR § 438.8(e)(2) Incurred claims.

(i) Incurred claims must include the following:

(B) *Unpaid claims liabilities for the MLR reporting period, including claims reported that are in the process of being adjusted or claims incurred but not reported.*

(F) *Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.*

IBNR Estimates (Subcapitated) – See guidance related to IBNR estimates above.

Paid Provider Incentive and Bonus Payments – Incentive and bonus payment amounts paid to providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards based on dates of service for the MLR reporting period. CMS defines a related party to be an entity that is associated with the health plan through any form of common, privately-held ownership, control, or investment. See the guidance in CMS Publication 15-1, Chapter 10. The objective ensures financial arrangements between a health plan and related parties are not significantly different from the financial arrangements that would have been achieved in the absence of the relationship.
Additionally, only provider incentive and bonus payment arrangements in compliance with the contractual and documentation requirements set forth in 42 CFR § 438.3(i)(3) and (4) will be considered for the MLR calculation.

42 CFR § 438.8(e)(2) Incurred claims.

(iii) Expenditures that must be included in incurred claims includes the following:

(A) *The amount of incentive and bonus payments made, or expected to be made, to network providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.*

IBNR for Provider Incentive and Bonus Payments – Unpaid incentive and bonus payment liabilities associated with the MLR reporting period. See guidance related to IBNR estimates above.

Value-Added Services (VAS) – e.g.; Vision and Transportation. Vision services for patients under 21 should not be included in VAS. VAS should not include the entire capitation payment amounts to delegated vendors, rather the portion identified as incurred claims paid expense by the delegated vendor to the medical provider or servicer. See commentary from the federal guidance (CMS-2439-F) for application. Under 42 CFR § 438.3(e)(1), a health plan may voluntarily cover, for enrollees, services that are in addition to those covered under the State plan. These services are often referred to as VAS, and the cost of these services may not be included in the capitation rate; however, as outlined in CMS-2390- F, VAS can be considered as incurred claims in the numerator for the purposes of the MLR calculation if the services are activities that improve health care quality under 45 CFR § 158.150 and are not excluded under 45 CFR § 158.150(c).

State Directed Payments Expense – All expenses related to state directed payment (SDP) revenues, including the Maryland Quality Innovation Program (M-QIP) and Trauma Fund.

42 CFR § 438.8(e)(2) Incurred claims.

(iii) Expenditures that must be included in incurred claims includes the following:

(C) *The amount of payments made to providers under State directed payments described in § 438.6(c).*

In Lieu of Services – In lieu of services are medically appropriate and cost-effective substitute services that are not covered services in the Department contract. If these are reflected in a paid lag, the expenses should not be reflected within Claims Paid (Non Subcapitated), but reported separately.

42 CFR § 438.3(e) Services that may be covered by an MCO, PIHP, or PAHP.

(2) An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:

(i) The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan;

(ii) The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting;

(iii) The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and

(iv) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

Incurred Claims Inclusions, Deductions, and Exclusions

Direct Fraud Recovery Expenses – Input amount of fraud reduction expenses excluding expenditures on activities related to fraud reduction. Fraud reduction activities are incurred subsequent to the payment of a claim to specifically identify and detect fraudulent claims for recoupment. All other post-payment claim review activities ensuring proper claim payment performed by the health plan as part of the program integrity duties are considered administrative expenses and should be reflected within Non- Claims Costs. The amount of fraud reduction expenses must not include expenditures on activities related to fraud prevention, defined below.

Direct Fraud Recoveries – Claims payments recovered through fraud reduction efforts should be included in incurred claims, not to exceed the amount of fraud reduction expenses.

42 CFR § 438.8(e)(2) Incurred claims.

(iii) Expenditures that must be included in incurred claims includes the following:

(B) The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph (e)(4) of this section.

Fraud prevention activity guidance is noted below, these are expenses incurred prior to the payment of a claim to prevent fraudulent claim payments and must exclude expenses directly related to the recovery of fraud-related claims. The CMS-2390-F rule commentary states, *"In light of our recent decision not to incorporate expenses for fraud prevention activities in the MLR for the private market within the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 final rule, which published in the March 8, 2016 Federal Register (81 FR 12204, 12322), we believe that it is similarly premature for Medicaid to adopt a standard for incorporating fraud prevention activities in the MLR. Consideration of fraud prevention activities should be aligned, to the extent possible, across MLR programs. Therefore, we will finalize § 438.8(e)(4) with the heading ''Fraud prevention activities'' and specify that ''MCO, PIHP, or PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158'' would be incorporated into the Medicaid MLR calculation in the event the private market MLR regulations are amended.* Therefore, these expenses are considered routine program integrity activities and should be reflected within line Expenditures related to activities compliant with 42 CFR § 438.608(a)(1) through (5), (7), (8), and (b).

42 CFR § 438.8(e)(4) Fraud prevention activities. MCO, PIHP, or PAHP expenditures on activities related to fraud prevention consistent with regulations adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.

Claim Recoveries Not included in Claims Paid – Claims that are recoverable for anticipated COB and claim payments recoveries received as a result of subrogation. Amounts are a reduction to incurred claims and should include any claim-related recoveries not captured in a paid lag. For example, COB is the payor payment amount when coverage exists in addition to Medicaid for the member or subrogation where the health plan is asserting a claim against an at-fault party.

42 CFR § 438.8(e)(2) Incurred claims.

(i) Incurred claims must include the following:

(D) Claims that are recoverable for anticipated coordination of benefits.

(E) Claims payments recoveries received as a result of subrogation.

Overpayment Recoveries from Providers – Overpayment recoveries received from providers must be deducted from incurred claims.

42 CFR § 438.8(e)(2) Incurred claims.

(ii) Amounts that must be deducted from incurred claims includes the following:

(A) Overpayment recoveries received from network providers.

Pharmacy Drug Rebates and Other types of Payments, Fees, or Adjustments (OPFA) – Amounts are a reduction to incurred claims. Note, spread pricing is not allowable as incurred claims, therefore, if pharmacy claims paid are reported based on amounts paid to the pharmacies within Claims Paid (Non Subcapitated), then the amount related to spread pricing should not be reduced from incurred claims.

- Prescription drug rebates accrued and received by the health plan must be deducted from incurred claims, regardless of whether the health plan acts on the collection process. This should include health plan rebates and rebates retained by the PBM.
- PBM and health plan contractual rate guarantee arrangements must be deducted from incurred claims.
- OPFA may be assessed to pharmacies by the PBM and not visible to the health plan. Any fees assessed, such as transmission fees, network access fees, contract rate guarantees, etc. that ultimately reduce the amount paid to the pharmacy and must be deducted from incurred claims. OPFA falls under the definition of "drug rebate." Contract rate guarantees requiring additional reimbursement to pharmacies from the PBM would be netted within as a positive value.
    - The Centers for Medicare & Medicaid Services (CMS) clarifies the below guidance to require anytime a health plan receives something of value for the provision of a Medicaid covered outpatient drug (e.g., manufacturer rebates, incentive payments, direct or indirect remuneration, goods in kind, etc.), regardless from whom the item of value is received (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, etc.), the value of that rebate must be deducted from the amount of incurred claims in the MLR calculation. See the Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin: Medicaid Prescription Spread Pricing, dated May 15, 2019 for additional guidance.

42 CFR § 438.8(e)(2) Incurred claims.

(ii) Amounts that must be deducted from incurred claims includes the following:

(B) Prescription drug rebates received and accrued.

Carve Out Services Reported in Claims Paid – Input any reductions for carve out services reported within Claims Paid (Non Subcapitated). If carve out services were excluded from claims paid reporting in paid lags, then input as a zero amount.

Provider Settlements Not Included in Claims Paid – Settlements should be reported based on date of service. If there are no settlements outside of the paid lag, then input as a zero amount.

Other Inclusions, Deductions, or Exclusions – Input any other expenses, not separately identified that should be reported.

42 CFR § 438.8(e)(2) Incurred claims.

(i) Incurred claims must include:

(C) Withholds from payments made to network providers.

(G) Changes in other claims-related reserves.

(H) Reserves for contingent benefits and the medical claim portion of lawsuits.

42 CFR § 438.8(e)(2) Incurred claims.

(iv) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

(v) Amounts to be excluded from incurred claims:

(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(4) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the State as remittance under paragraph (j) of this section.

(C) Amounts paid to network providers under to § 438.6(d).

<u>HCQI, HIT, and EQR Expenditures</u>

Guidance for HCQI, HIT, and EQR expenses is outlined below.

HCQI Guidance

42 CFR § 438.8(e)(3) Activities that improve health care quality. Activities that improve health care quality must be in one of the following categories:

(i) An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR § 158.150(a) and (b) and is not excluded under 45 CFR § 158.150(c).

(ii) An MCO, PIHP, or PAHP activity related to any EQR-related activity as described in § 438.358(b) and (c).

(iii) Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found

in 45 CFR § 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.

45 CFR § 158.150 specifically defines the allowable and non-allowable activities related to this expense. The expense must be directly related to the improvement of the health care quality. Direct administrative costs that do not qualify as allowable quality improvement cost should be excluded from the MLR calculation. Specific reporting treatment for HCQI is noted below.

45 CFR § 158.150(a) General requirements. The report required in § 158.110 must include expenditures directly related to activities that improve health care quality, as such activities are described in this section.

45 CFR § 158.150(b) Activity requirements. Activities conducted by an issuer to improve quality must meet the following requirements:

(1) The activity must be designed to:

(i) Improve health quality.

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees.

(iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

Additional examples and further categorization are provided in the guidance at 45 CFR § 158.150(b)(2).

Vendor costs for quality improvement activities (QIA), per clarifying CMS guidance, outline expenses that must be reported at the cost of the vendor providing services. Vendors are limited to the same costs that could be claimed by the health plan should they have done it themselves internally. CMS states *"Where an issuer performs its own QIA without engaging a vendor, any ''profit'' that it makes on such QIA cannot be included in the MLR calculation. Accordingly, where an issuer chooses to outsource its QIA to a third party, rather than developing the necessary skills in-house, as it does for other issuer functions such as claims processing, network development, clinical policies, and case and utilization management, for example, for MLR reporting and rebate purposes that vendor stands in the shoes of the issuer. Consequently, the vendor's indirect costs, as well as any profit, cannot be reported as a QIA expense that is included in the MLR calculation."*

Indirect or overhead costs have now been specifically identified as non-allowable for reporting of HCQI. Commentary within the Marketplace guidance includes specific

examples such as *"Office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, computer and telephone usage, travel and entertainment, company parties and retreats, IT systems, and marketing of issuers' products."* This was clarified further in the CMS 2439-F rule to align with Marketplace, reference commentary.

45 CFR § 158.150(c) Exclusions. Expenditures and activities that must not be included in quality improving activities are:

(1) Those that are designed primarily to control or contain costs;

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;

(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD–10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended.

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

(7) All retrospective and concurrent utilization review;

(8) Fraud prevention activities;

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(10) Provider credentialing;

(11) Marketing expenses;

(12) Costs associated with calculating and administering individual enrollee or employee incentives;

(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

(14) Any function or activity not expressly included in paragraph (a) or (b) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the

definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

HIT Guidance

45 CFR § 158.151 allows HIT expenses to be included to the extent expenses are required to accomplish the activities allowed as HCQI expense. In order to qualify as an allowed HIT expense, the expense must, in whole or in part, contribute to improving the quality of care, provide the technological infrastructure to enhance current quality improvement, or make new quality improvement initiatives possible.

45 CFR § 158.151(a) General requirements. An issuer may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in § 158.150 of this subpart and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in § 158.140 of this subpart;

(2) Implementing systems to track and verify the adoption of meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health record technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as the NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.

(6) Advancing the ability of enrollees, providers, issuers, or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.

(7) Reformatting, transmitting, or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self- management.

HIT clarifications from CMS include disallowing allocations of general use software. CMS specifically disallows the allocation of dual functioning systems that serve primarily for functions outside of QIA. Unless the software is primarily related to QIA activities, it cannot be included. CMS states, *"We affirm and clarify that HIT expenses that meet the applicable requirements in §§ 158.150 and 158.151 are permissible costs that can be included as QIA expenses. For example, the cost of software designed and used primarily for QIA purposes, such as HEDIS reporting, constitutes a direct expense related to activities that improve health care quality and can be included in QIA expenses for MLR reporting and rebate purposes. In contrast, as explained above and in the proposed rule, the costs of IT infrastructure that primarily supports regular business functions such as billing, enrollment, claims processing, financial analysis, and cost containment, even when the same IT infrastructure also happens to support QIA activities in addition to regular business functions, do not constitute a direct expense related to activities that improve health care quality and cannot be included in QIA expenses for MLR reporting and rebate purposes."* This was clarified further in the CMS-2439-F rule, reference commentary.

EQR Guidance

Include any EQR-related activity as described in 45 CFR § 438.358(b) and (c) as noted below.

42 CFR § 438.358(b) Mandatory activities.

(1) For each MCO, PIHP, or PAHP the following EQR-related activities must be performed:

(i) Validation of performance improvement projects required in accordance with § 438.330(b)(1) that were underway during the preceding 12 months.

(ii) Validation of MCO, PIHP, or PAHP performance measures required in accordance with § 438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months.

(iii) A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D of this part, the disenrollment requirements and limitations described in § 438.56, the enrollee rights requirements described in § 438.100, the emergency and post-stabilization services requirements described in § 438.114, and the quality assessment and performance improvement requirements described in § 438.330.

(iv) Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in § 438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, § 438.14(b)(1).

(2) For each PCCM entity (described in § 438.310(c)(2)), the EQR-related activities in paragraphs (b)(1)(ii) and (iii) of this section must be performed.

42 CFR § 438.358(c) Optional activities. For each MCO, PIHP, PAHP, and PCCM entity (described in § 438.310(c)(2)), the following activities may be performed by using information derived during the preceding 12 months:

(1) Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)).

(2) Administration or validation of consumer or provider surveys of quality of care.

(3) Calculation of performance measures in addition to those reported by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) and validated by an EQRO in accordance with paragraph (b)(1)(ii) of this section.

(4) Conduct of performance improvement projects in addition to those conducted by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) and validated by an EQRO in accordance with paragraph (b)(1)(i) of this section.

(5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

(6) Assist with the quality rating of MCOs, PIHPs, and PAHPs consistent with § 438.334.

Costs For Reporting Purposes Only

Expenditures related to activities compliant with 42 CFR § 438.608(a)(1) through (5), (7), (8), and (b) – Input expenditures related to administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse and costs to ensure provider screening and enrollment requirements. See Worksheet 7 Program Integrity for additional reporting instructions.

42 CFR § 438.608(a) Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse.

(1) A compliance program that includes, at a minimum, all of the following elements:

(i) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

(ii) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.

(iii) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

(iv) A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.

(v) Effective lines of communication between the compliance officer and the organization's employees.

(vi) Enforcement of standards through well-publicized disciplinary guidelines.

(vii) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

(2) Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

(3) Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:

(i) Changes in the enrollee's residence;

(ii) The death of an enrollee.

(4) Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP.

(5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

(7) Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

(8) Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23 of this chapter.

42 CFR § 438.608(b) Provider screening and enrollment requirements. The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E

of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.

Non-Claims Costs – All other expenses that are not classified as program integrity, incurred claims, or HCQI/HIT/EQR are Non-Claims Costs. Non-Claims Costs are non-determinate of allowability, not included in the MLR calculation, and are informational only.

42 CFR § 438.8(b) Definitions. As used in this section, the following terms have the indicated meanings:

Non-claims costs means those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e)(2) of this section); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of this section); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of this section).

42 CFR § 438.8(e)(2)(v)(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(1) Amounts paid to third party vendors for secondary network savings.

(2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3€ and provided to an enrollee.

(4) Fines and penalties assessed by regulatory authorities.

<u>Revenue</u>

Premium revenue is included as the denominator of the MLR calculation, and defined in 42 CFR § 438.8(f)(2), and reflects revenues received from the Department for the MLR reporting period.

Premium Revenue Inclusions

Capitation Revenue Including Delivery Kick Revenues and Excluding Rural Health and PHIP – Capitation revenues are payments agreed upon in a capitation contract by the health plan and the Medicaid agency for providing core benefits and services as defined in the terms of the contract. A fixed, pre-arranged monthly payment is received by the health plan for each member enrolled with the health plan. The guidance is noted below in (i). The Maternity Case Rate/Kick Payments, noted below in (ii) for the one-time payments for specific life events are developed within the capitation payments.

Payments deemed as pass-through payments per 42 CFR § 438.6(d) should not be included within the MLR calculation.

42 CFR § 438.8(f)(2) Premium revenue. Premium revenue includes the following for the MLR reporting year:

(i) State capitation payments, developed in accordance with § 438.4, to the MCO, PIHP, or PAHP for all enrollees under a risk contract approved under § 438.3(a), excluding payments made under § 438.6(d).

(ii) State-developed one-time payments, for specific life events of enrollees.

(iii) Other payments to the MCO, PIHP, or PAHP approved under § 438.6(b)(3).

Health plan incentive payments developed under 42 CFR § 438.6(b)(2) should be excluded for MLR reporting purposes. This includes Rural Access Incentive Supplemental Payments and the Population Health Improvement Program (PHIP) payments. See below for commentary on health plan incentive payments.

CMS commentary explains that *"incentive payments made to the managed care plan in accordance with 438.6(b)(2) should not be included in the denominator as such payments are in addition to the capitation payments received under the contract. The limit on incentive arrangements in § 438.6(b)(2) is not impacted by the requirements in § 438.8. However, payments earned by managed care plans under a withhold arrangement, as specified at § 438.6(b)(3), should be accounted for in premium revenue for purposes of the MLR calculation because the amount of the withhold is considered in the rate development process and reflected in the rate certification. To that end, we are finalizing § 438.8(f)(2)(iii) to clarify that payments to the MCO, PIHP, or PAHP that are approved under § 438.6(b)(3) are included as premium revenue. Amounts earned by the managed care plans under a withhold arrangement will be included in the denominator as premium revenue. Any amounts of the withhold arrangement that are not paid to the managed care plans would not be included as premium revenue."*

42 CFR § 438.6(b)(2) Basic requirements. Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound. For all incentive arrangements, the contract must provide that the arrangement is—

(i) For a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Does not condition MCO, PIHP, or PAHP participation in the incentive arrangement on the MCO, PIHP, or PAHP entering into or adhering to intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy at § 438.340.

State Directed Payments Revenue – Input amounts for SDP revenue, including M-QIP and Trauma Fund payments.

42 CFR § 438.8(f)(2) Premium revenue. Premium revenue includes the following for the MLR reporting year:

(vii) Payments to the MCO, PIHP, or PAHP for expenditures under State directed payments described in § 438.6(c).

Accrued Risk Corridor Payments/Receipts – The risk corridor calculation is considered a proper risk- sharing mechanism and captured within the MLR calculation.

Net reinsurance premiums and recoveries are potentially reportable based on (vi) below, provided that this is an approved risk sharing mechanism and meets the appropriate development criteria. However, since reinsurance is not contractually mandated in Maryland, this is considered a non-approved risk sharing mechanism and should be excluded from the MLR reporting. If participating in the Department's stop loss program, amounts paid directly (or deducted from premium revenue) for reinsurance premiums should be removed (or added back) to reflect the full capitation, exclusive of any reinsurance transactions.

42 CFR § 438.8(f)(2) Premium revenue.

(vi) Net payments or receipts related to risk sharing mechanisms developed in accordance with § 438.5 or § 438.6.

Mid-Year Supplemental Capitation Adjustment – See guidance requirements above 42 CFR § 438.8(f)(2).

Hepatitis C Capitation Risk Pool Settlement – See guidance requirements above 42 CFR § 438.8(f)(2).

Federally Qualified Health Center (FQHC) Payments – See guidance requirements above 42 CFR § 438.8(f)(2).

Other Revenues – Paid by the Department to the health plan, in addition to capitation for covered services, not included in any other revenues listed above. This should include risk corridor amounts for the Diabetes Prevention Program and for the Maternal and Child, if applicable.

42 CFR § 438.8(f)(2) Premium revenue.

(iv) Unpaid cost-sharing amounts that the MCO, PIHP, or PAHP could have collected from enrollees under the contract, except those amounts the MCO, PIHP, or PAHP can show it made a reasonable, but unsuccessful, effort to collect.

(v) All changes to unearned premium reserves.

Premium Revenue Deductions

Premium Taxes – If applicable, input the amount of premium tax due to the Maryland Department of Insurance associated with the capitation/premium revenue, settlements, and SDPs based on the general ledger. These amounts are calculated based on the State's required premium tax rate applied to gross premiums. Review the State's administrative code to determine if the health plan is exempt from paying premium taxes.

42 CFR § 438.8(f)(3) Federal, State, and local taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees for the MLR reporting year include:

(iv) State and local taxes and assessments including:

(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

Federal, State, and Local Income Taxes – Input federal, state, and local income tax amounts for the MLR reporting period, based on the general ledger.

Remove taxes related to investment income, and if applicable, factor in the change in deferred tax assets. Amounts should be reported consistently year over year, using the same methodology (GAAP or Statutory Accounting Principles [SAP]). If the health plan changes the methodology across all lines of business, an explanation should be input for the basis for the change, see instructions within Worksheet 4.

42 CFR § 438.8(f)(3) Federal, State, and local taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees for the MLR reporting year include:

(iii) Federal taxes and assessments allocated to MCOs, PIHPs, and PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

(iv) State and local taxes and assessments including:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

(B) Guaranty fund assessments.

(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

Other Taxes, Licensing, and Regulatory Fees – Input the Health Insurance Stabilization Assessment (HISA) tax amount and any other qualifying taxes and fees based on guidance below.

42 CFR § 438.8(f)(3) Federal, State, and local taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees for the MLR reporting year include:

(i) Statutory assessments to defray the operating expenses of any State or Federal department.

(ii) Examination fees in lieu of premium taxes as specified by State law.

Community Benefit Expenditures – Input amounts for community benefit expenditures (CBE) are reserved for not-for-profit health plans exempt from federal income taxes.

Community Benefit Expenditures Percentage Calculated - Limited to 3% – Health plans are limited to three percent of earned premiums or the highest premium tax rate in the State, whichever is greater.

42 CFR § 438.8(f)(3) Federal, State, and local taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees for the MLR reporting year include:

(v) Payments made by an MCO, PIHP, or PAHP that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:

(A) Three percent of earned premium; or

(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.

45 CFR § 158.162(c) Community benefit expenditures. Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:

(1) Are available broadly to the public and serve low-income consumers;

(2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);

(3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;

(4) Leverage or enhance public health department activities such as childhood immunization efforts; and

(5) Otherwise would become the responsibility of government or another tax-exempt organization.

<u>Federal MLR Calculation</u>

Unadjusted MLR – The Unadjusted MLR percentage for each health plan in a MLR reporting period is the ratio of the benefit expense (numerator) to the revenue (denominator). The MLR will be expressed as a percentage rounded to the first decimal

place. For example, an MLR calculated at 84.9 percent does not meet the minimum MLR requirement of 85 percent.

MLR Credibility – The credibility adjustment is calculated based on the table in Worksheet 3. See Worksheet 3 – Credibility Table for additional information.

Adjusted MLR – The Adjusted MLR percentage is the sum of the Unadjusted MLR and the Credibility Adjustment. The Adjusted MLR percentage is expressed as a percentage, rounded to the first decimal place.

Contract Includes Remittance Requirement – A remittance is required based on HealthChoice contractual requirements. Based on federal guidance, states have the option to implement a remittance. If the health plan does not meet the required MLR, the health plan must refund the Department based on the prescribed calculation with the MLR Reporting Template.

State Minimum MLR Requirement – A minimum MLR of 85 percent aggregate for all covered populations must be reported for each MLR reporting year.

Calculated MLR for Remittance Purposes – The MLR percent to be compared to the required minimum to determine the remittance dollar amount owed.

Remittance Dollar Amount Owed for MLR Reporting Period – If applicable based on the health plan contract, the amount owed to the Department for the MLR reporting period. A health plan may appeal the remittance as a sanction pursuant to COMAR 10.67.10.02.

Member Months

Member Months – Member months represents the number of months an enrollee or a group of enrollees is covered by the health plan for the MLR reporting period. Although the member months are not used in the MLR calculation itself, 42 CFR §§ 438.74(a)(2) 438.8 (k)(xiii) requires that member months be reported on the MLR.

WORKSHEET 3 – CREDIBILITY TABLE

The credibility adjustment is calculated to the MLR percentage achieved if the MLR reporting period experience is partially credible based on the number of member months in the MLR reporting period. The credibility adjustment is added to the MLR percentage achieved prior to comparison to the MLR requirement and remittance calculation. On July 31, 2017, CMS published an Information Bulletin, Medical Loss Ratio (MLR) Credibility Adjustments, which provides an overview and methodology for credibility adjustments in the CMS MLR formula. If the MLR period is not a full reporting year, member months will be annualized for the credibility calculation.

CMS will publish base credibility factors that are developed according to 42 CFR § 438.8(h), as needed.

- The CMS credibility adjustment is used to account for random statistical variation related to the number of enrollees in a health plan.
- The credibility adjustment categorizes health plans into three groups:
    - **Fully Credible** – Health plans with sufficient claims experience, measured in terms of member months, are assumed to experience MLRs that are not subject to random variation as observed in statically insignificant samples. Such health plans will not receive a credibility adjustment for the MLRs.
    - **Partially Credible** – Health plans with sufficient claims experience, measured in terms of member months, to calculate an MLR with a reasonable chance that the difference between the actual and target MLR is statistically significant. Such health plans will receive a partial credibility adjustment to the calculated MLRs.
    - **Non-Credible** – Health plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR. Such plans will not be measured against the MLR standard. Health plans in this group are presumed to meet or exceed the target MLR standard.

WORKSHEET 4 – ALLOCATION METHODOLOGY EXPLANATIONS

Allocation of Expense

The health plan should utilize consistent allocation factors between MLR reporting periods and reporting entities and are required to submit methodology(ies) for allocation of expenditures per 42 CFR § 438.8(k)(1)(vii). Reporting will apply to Incurred Claims Expenditures; Incurred Claims Inclusions, Deductions, and Exclusions; HCQI, HIT, and EQR Expenditures; Revenue Deductions; and Non-Claims Costs. Additionally, a drop down is included to input the tax reporting basis utilized (GAAP or SAP).

42 CFR § 438.8(g) Allocation of expense -

(1) General requirements.

(i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

(2) Methods used to allocate expenses.

(i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(iii) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

42 CFR § 438.8(k) Reporting requirements -

(1) The State, through its contracts, must require each MCO, PIHP, or PAHP to submit a report to the State that includes at least the following information for each MLR reporting year:

(vii) Methodology(ies) for allocation of expenditures, which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR § 158.170(b).

45 CFR § 158.170 Allocation of expenses -

(b) Description of the methods used to allocate expenses. The report required in § 158.110 must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non- claims costs, to each health insurance market in each State. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

(1) Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the issuer should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses.

(2) Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.

(3) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

WORKSHEET 5 – ANNUAL FINANCIAL RECONCILIATION STATEMENT

Complete a comparison of the annual MLR reported information to the audited financial report required under 42 CFR § 438.3(m). Include audited financial statements with an underwriting exhibit reflecting HealthChoice only experience for the current year.

For each reporting category enter the corresponding amount from the audited financial statements, the MLR amounts will automatically populate from Worksheet 2 – MLR Calculation. For any variance, provide an explanation for the difference.

WORKSHEET 6 – ATTESTATION AND MLR REPORTING TEMPLATE INSTRUCTIONS

The health plan must attest to the accuracy of the MLR calculation in accordance with requirements of these instructions when submitting the required report [42 CFR § 438.8(n)].

Submit the certification by the health plan's CEO or CFO that data within the MLR Reporting Template is accurate and representative of health plan experience for the reporting period. The health plan must attest to the accuracy of the MLR calculation in accordance with the instructional requirements when submitting the required report.

42 CFR § 438.8(n) Attestation. MCOs, PIHPs, and PAHPs must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph (k) of this section.

WORKSHEET 7 – PROGRAM INTEGRITY

Input the detail of program integrity costs by reporting category, additional categories may be added as needed, to equal amounts reported within the MLR calculation. For each reporting category, provide a description of the services provided and any relevant notes or explanations. See guidance in Worksheet 2.

APPENDIX H
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 participants. MCOs must offer MOM case management services to eligible members as a first option for case management.

MCOs are responsible for outreaching potential participants about MOM each month as part of their recruitment responsibilities. These activities should be documented in the Outreach Attempt Log, submitted to MDH monthly.

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-ups (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 case management services, along with ongoing and substantive outreach; and

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

APPENDIX 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.

8. Financial sanctions under the threshold of $50,000 are not appealable.

APPENDIX J
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, and align with the AHEAD model. 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. Doctor 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. In alignment with the AHEAD model, Medicaid will begin quality payments to primary care practices starting in CY 2026. A subset of Eligible Providers will participate in the Maryland Primary Care Program (MDPCP), for which HealthChoice will begin quality alignment in CY 2023 and payment alignment starting in CY 2025. To prevent duplicative quality-based payments in the aligned program, beginning in CY 2025, 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.

APPENDIX K
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]

[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.

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] 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

[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.

[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.)

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).

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

[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.

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.

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]

[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

						Virtual programs may only use VM to indicate make-up sessions. Do not use GT **and** VM **OR** GT **and** TS
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

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

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
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

APPENDIX L-1
HIGH-COST LOW VOLUME DRUG RISK MITIGATION POLICY

Maryland's Department of Health (MDH) 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 CYs 2021 to 2023. This threshold was changed to $500,000 for CY 2024.

The specific drugs covered are listed in Exhibit I of this document. This policy is applicable only to Covered Outpatient Drugs as defined in 42 CFR 447.502. 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 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 2024)

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
Anktiva	81481-0803-01	J9399
Benefix	58394-0633-03, 58394-0634-03, 58394-0635-03, 58394-0636-03, 58394-0637-03	J7195
Beqvez	00069-0422-01, 00069-2004-04, 00069-2004-14, 00069-2005-05, 00069-2005-15, 00069-2006-06, 00069-2006-16, 00069-2007-07, 00069-2017	J3590
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,	J3490, J3590

Drug Name	NDC Code	HCPCS Code (if Applicable)
	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, 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
Fabhalta	00078-1189-20	J8499
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
Hemlibra	50242-0920-01, 50242-0921-01, 50242-0922-01, 50242-0923-01, 50242-0927-01, 50242-0930-01	J7170

Drug Name	NDC Code	HCPCS Code (if Applicable)
Jivi	00026-3942-25, 00026-3944-25, 00026-3946-25, 00026-3948-25	J7208
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, 72542-0500-02, 72542-0500-18, 72542-0600-02, 72542-0600-18, 72542-0367-01, 72542-0667-02, 72542-0667-18	J8499
Orladeyo	72769-0101-01, 72769-0102-01	J8499
Oxlumo	71336-1002-01	J0224
Pombiliti	71904-0200-01, 71904-0200-02, 71904-0200-03	J1203
Procysbi	75987-0101-08	J8499
Ravicti	75987-0050-06	J8499
Rethymic	72359-0001-01	J3590
Revcovi	57665-0002-01	J3590, J3490
Rivfloza	00169-5306-10, 00169-5307-08, 00169-5308-01	J3490
Roctavian	68135-0927-01, 68135-0927-48	J3490, J3590
Ryplazim	70573-0099-01, 70573-0099-02	J2998
Sohonos	15054-0010-01, 15054-0015-01, 15054-0025-01, 15054-0050-01, 15054-0100-01	J8499
Soliris	25682-0001-01	J1300
Spinraza	64406-0058-01	J2326
Takhzyro	47783-0644-01	J0593
Veopoz	61755-0014-01	J3590
Viltepso	73292-0011-01	J1427
Vimizim	68135-0100-01	J1322
Vyjuvek	82194-0510-02	J3590

Drug Name	NDC Code	HCPCS Code (if Applicable)
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

APPENDIX L-2
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 2025. 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 +/- 4%.
    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.

APPENDIX L-3
MODERATE COST HIGH VOLUME DRUG RISK MITIGATION POLICY

MDH is implementing a risk corridor for moderate cost, high volume drugs in the capitation rates, while controlling for differences in treatment volume across MCOs for calendar year 2025. GLP-1 prescription drugs for the treatment of diabetes are excluded from this risk corridor. The estimated payment threshold of $30M will be used to incorporate a risk corridor for a drug or a class of drugs. After the contract period has ended, the prescriptions for the drug or class of drugs provided by each 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 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.

APPENDIX M
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 CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) (I) Patient Access API (42 CFR 422.119(b)(b)(5)); (II) Provider Access API (45 CFR 156.222(a)(2)); (III) Payer to Payer API (45 CFR 156.222(b)(1)); (IV) Prior Authorization API (42 CFR 422.122(b). Each MCO must implement and maintain a secure, HL7 FHIR Release 4.0.1 standards-based API. All APIs are required to be implemented by January 1, 2027.

I. **Patient Access API.** To allow patients to easily access their claims information, including cost, as well as a defined subset of clinical information. Starting January 1, 2026, MCOs must annually report certain metrics to CMS about patient data requests made via the Patient Access API.
II. **Provider Access API.** To maintain a system which includes adjudicated claims and encounter data and excludes provider remittances and patient cost-sharing information.
III. **Payer-to-Payer API.** 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. MCOs will be required to request data from a patient's previous payor, with the patient's permission, no later than one (1) week from the start of the coverage or at the patient's request.
IV. **Prior Authorization API.** To communicate whether the payer approves the prior authorization request, denied the request, or requests more information.

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/2025/02/08/2025-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability#h-125.

APPENDIX N
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 2025, PHIP will be funded at 0.5% of HealthChoice total capitation for the measurement year, based on funds available in MDH's FY 2025 and FY 2026 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.

Beginning in measurement year 2025, an MCO that has a finding under the HEDIS Performance Monitoring Policies in Appendix D of this Agreement will be excluded from all rounds of PHIP for that measurement year.

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 prior 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 prior 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 prior 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 prior 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 their performance in the previous measurement year, and
2) The performance measure score is at or above the 50th percentile of prior measurement year national HEDIS Medicaid HMO performance on a HEDIS-based measure, or the 50th percentile of prior year 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. Incentive payments and exclusions from PHIP participation are not appealable under this agreement or COMAR 10.67.10.01.

APPENDIX O
HEALTHCHOICE HEALTH EQUITY INCENTIVE METHODOLOGY

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, 2025.

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 2025, a total of $8 million is allocated for this incentive across the Maryland HealthChoice Program. The incentive amount your MCO will receive for CY 2025 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) 2025 and 2026. 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 2025, 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 2025, 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.

APPENDIX P
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.

APPENDIX Q
HEALTHCHOICE AND MARYLAND PRIMARY CARE PROGRAM ALIGNMENT

This policy outlines the requirements for MCOs participating in HealthChoice regarding designing and implementing an advanced primary care program that aligns with the principles of the Maryland Primary Care Program (MDPCP). The new payment requirements will be addressed as a new benefit at the mid-year rate-setting process.

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 2025 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 July 1, 2025. MCOs will provide participating providers with information on members who are attributed to these practices, following execution of the respective provider contracts.

III. Increased Rates Evaluation and Management for Primary Care Providers

As directed by the Department via policy transmittal, MCOs will implement increased Evaluation and Management (E&M) rates, i.e., as a percentage of Medicare, for all primary care practices eligible for member assignment, in line with the Department's definition of a primary care provider.

IV. Care Management Fees

MCOs will provide care management fees to qualifying primary care providers. The Department will define practice eligibility, care management eligibility, and other program parameters via policy transmittal.

V. Mid-Year Adjustment

Additional payments to primary care providers under the Medicaid Aligned Program will be made at mid-year.

VI. Quality Measurement and Incentive Strategy

MCOs will comply with required activities to implement a quality measurement and incentive strategy for qualifying primary care practices, to be developed by the Department and communicated via policy transmittal.

APPENDIX R
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 definitions 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 overall 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;
ii. Assessment of whether encounter data supports MDH's determination that each ILOS is a medically appropriate and cost-effective substitute for identified covered services and settings under the State Plan;
iii. The final ILOS Cost Percentage for each year;
iv. Appeals, grievances, and state fair hearings data, reported separately and for each ILOS, including volume, reason, resolution status, and trends; and
v. Impact each ILOS had on health equity initiatives and efforts undertaken by the state to mitigate health disparities.

b. Evaluations are due to CMS no later than 24 months after the completion of the first five contract years that include ILOSs.

APPENDIX S
INTEGRATED MATERNAL HEALTH SERVICES INITIATIVE

To assist with the implementation of the Integrated Maternal Health Services initiative, MDH will work with the HealthChoice managed care organizations (MCOs) to collect the following information quarterly beginning January 1, 2025, for all counties, pending a data use agreement permitting the sharing of aggregated data with the lead administration for the grant:

1. Number of pregnancy care managers/care coordinators at the MCO (including changes to staffing by quarter).
2. Number of individuals identified as pregnant in the MCO at the time of the reporting period.
3. Number of pregnant people for which the MCO has received a standardized risk assessment from the administrative care coordination unit (ACCU) at the local health departments in Maryland.
4. Percentage of pregnant people identified at greater risk for adverse maternal health outcomes, based on responses to the Maryland Prenatal Risk Assessment.
5. Percentage of pregnant people identified at greater risk for adverse maternal health outcomes who receive care management.
6. Percentage of program participants who receive care management services as part of the IMHS model and are identified as needing additional clinical, behavioral health, and/or social services.
7. Percentage of program participants who are identified as needing additional clinical, behavioral health, and/or social services and are referred to additional services.
8. Percentage of referrals to additional services that resulted in program participants receiving services.
9. Percentage of program participants with a usual source of care/medical home identified at the end of program participation at the time of reporting.
10. Percentage of program participants screened for maternal depression at the time of reporting, stratified by:
    a. Prenatal depression screening.
    b. Postpartum depression screening.

To provide this information for purposes of IMHS, the information collected by each MCO will be aggregated for purposes of statistical analysis. MDH will work collaboratively with the MCOs in Fall 2024 to develop a reporting mechanism for these IMHS metrics.

HealthChoice MCOs may also participate in steering committees and other working groups related to the IMHS.