PT 14-04

STATE OF MARYLAND
DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 46

October 14, 2003

TO: Managed Care Organizations

FROM: Susan Tucker, Executive Director
Office of Health Services

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

RE: Proposed Amendments to HealthChoice Regulations

ACTION:
Proposed Regulations

PROPOSED EFFECTIVE DATE:
January 1, 2004

WRITTEN COMMENTS TO:
Michele Phinney
201 W. Preston St., Rm. 538
Baltimore, MD 21201
Fax (410) 767-6483 or call
(410) 767-6499 or
1-877-4MD-DHMH extension 6483

PROGRAM CONTACT:
Division of HealthChoice Management
(410) 767-1482 or call
1-877-4MD-DHMH extension 1482

COMMENT PERIOD EXPIRES: November 3, 2003

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.01** under **COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions**; amend Regulations **.01** and **.02** under **COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment**; amend Regulation **.03** under **COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application**; amend Regulations **.02**, **.03**, **.05**, **.10**, **.15**, **.17**, **.18-1**, **.19**, **.19-3**, **.21**, and **.26** and repeal Regulations **.19-4** and **.24** and adopt new Regulations **.19-4** and **.24** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations**; amend Regulations **.03** and **.07** and adopt new Regulation **.05-1** under **COMAR 10.09.66 Maryland Medicaid Managed Program: Access**; amend

Regulations **.01**, **.06**, **.10**, **.13**, **.14**, **.20**, and **.27** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**; amend Regulation **.02** under **COMAR 10.09.71 Maryland Medicaid Managed Care Program; MCO Dispute Resolution Procedures;** and adopt new Regulations **.01- .04** under new chapter, **COMAR 10.09.75 Maryland Medicaid Managed Care Program: Corrective Managed Care.**

The proposed amendments will:

1. Amend the Health General Article references and remove COMAR references that are no longer applicable.
2. Revise language to reflect that the criteria for coverage of services for enrollees 21 years old and younger consist of medical necessity, not appropriateness.
3. Add language to clarify that children enrolled in MCHP premium do not have a six-month eligibility guarantee, which is based on legislation passed during the 2003 session.
4. Remove the MCO requirement of having to provide adult dental benefits in order to be eligible for the random assignment of enrollees who failed to select an MCO.
5. Add language to differentiate between what self-insured MCOs versus all other MCOs are required to submit in their MCO applications to show compliance with Maryland's Workers' Compensation Law.
6. Amend the conditions of participation language to require the MCOs to notify the Department of their intent to accept new enrollees over the next calendar year by October 1st of the previous year.
7. Clarify the timeframe in which MCOs are required to report suspected fraud and abuse cases to the Medicaid Fraud Control Unit.
8. Revise the quality assessment and improvement regulation to clarify that MCOs are required to follow the requirements under COMAR 10.09.65.03 to have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees, including those with special health care needs.
9. Add new language defining the qualifications of HIV/AIDS specialists and allowing individuals to choose an HIV/AIDS specialist as their primary care provider.
10. Amend the data collecting and reporting regulation to specify reporting requirements for complaint logs and pre-service denials.
11. Remove the language requiring MCOs to submit the EPSDT report (form HCFA-416).
12. Establish new MCO rates for the time period of January 2004 through December 2004.
13. Add new language that requires the Department to provide the MCOs with supplemental payments for increases in provider payments for trauma services that are the result of 2003 legislation (House Bill 1/ Senate Bill 479).
14. Clarify the MCO qualifications for the statewide supplemental payment.
15. Repeal the Department payments to MCOs to support HIPAA compliance and define the payment rate methodology for new Medicaid managed care enrollees.
16. Amend the MCO per visit medical and dental reimbursement rates for Federally Qualified Health Centers (FQHCs).

17. Revise the enhanced dental plan regulation to only reflect the utilization target for calendar year 2004.
18. Amend the time period that MCOs can terminate their agreement with the Department to participate in the HealthChoice Program.
19. Clarify that MCOs are required to ensure medical appointments are scheduled for their enrollees.
20. Add new regulations that require the MCOs to meet certain specialty provider network requirements.
21. Remove clinical and pharmacy access language that was relevant to the first six months of the HealthChoice Program.
22. Ensure that the criteria providers are required to use during their substance abuse placement appraisals are consistent throughout the regulation.
23. Add new language to clarify that MCOs are responsible for the payment of any durable medical equipment authorized for enrollees even if delivery of the item occurs within 90 days after the member's disenrollment from the MCO, as long as the member remains Medicaid eligible during the 90 day time period.
24. Amend benefits limitation language to clarify that the Department is responsible for the purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers.
25. Amend benefits limitation language to clarify that the Department is responsible for the new prescription drug enfuvirtide, which is used to treat HIV/AIDS.
26. Add a new chapter, COMAR 10.09.75, to allow MCOs to establish corrective managed care programs for individuals determined to have abused MCO benefits.

A copy of these proposed amendments as published in the October 3, 2003 Maryland Register is attached to this transmittal.

Attachment

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[03-282-P]

The Secretary of Health and Mental Hygiene proposes to:

(1) Amend Regulation **.01** under **COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions;**

(2) Amend Regulations **.01** and **.02** under **COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment;**

(3) Amend Regulation **.03** under **10.09.64 Maryland Medicaid Managed Care Program: MCO Application;**

(4) Amend Regulations **.02**, **.03**, **.05**, **.10**, **.15**, **.17**, **.18-1**, **.19**, **.19-3**, **.21**, and **.26** and repeal Regulations **.19-4** and **.24** and adopt new Regulations **.19-4** and **.24** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations;**

(5) Amend Regulations **.03** and **.07** and adopt new Regulation **.05-1** under **COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access;**

(6) Amend Regulations **.01**, **.06**, **.10**, **.13**, **.14**, **.20**, and **.27** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**;

(7) Amend Regulation **.02** under **COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures**; and

(8) Adopt new Regulations **.01 — .04** under a new chapter, **COMAR 10.09.75 Maryland Medicaid Managed Care Program: Corrective Managed Care**.

Statement of Purpose

The purposes of these actions are to:

(1) Amend the Health-General Article references and remove COMAR references that are no longer applicable.

(2) Revise language to reflect that the criteria for coverage of services for enrollees 21 years old and younger consist of medical necessity, not appropriateness.

(3) Add language to clarify that children enrolled in MCHP premium do not have a 6-month eligibility guarantee, which is based on legislation passed during the 2003 session.

(4) Remove the MCO requirement of having to provide adult dental benefits in order to be eligible for the random assignment of enrollees who failed to select an MCO.

(5) Add language to differentiate between what self-insured MCOs versus all other MCOs are required to submit in their MCO applications to show compliance with Maryland's Workers' Compensation Law.

(6) Amend the conditions of participation language to require the MCOs to notify the Department of their intent to accept new enrollees over the next calendar year by October 1 of the previous year.

(7) Clarify the time frame in which MCOs are required to report suspected fraud and abuse cases to the Medicaid Fraud Control Unit.

(8) Revise the quality assessment and improvement regulation to clarify that MCOs are required to follow the requirements under COMAR 10.09.65.03 to have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees, including those with special health care needs.

(9) Add new language defining the qualifications of HIV/AIDs specialists and allowing individuals to choose an HIV/AIDS specialist as their primary care provider.

(10) Amend the data collecting and reporting regulation to specify reporting requirements for complaint logs and preservice denials.

(11) Remove the language requiring MCOs to submit the EPSDT report (form HCFA-416).

(12) Establish new MCO rates for the time period of January 2004 through December 2004.

(13) Add new language that requires the Department to provide the MCOs with supplemental payments for increases in provider payments for trauma services that are the result of 2003 legislation (House Bill 1/Senate Bill 479).

(14) Clarify the MCO qualifications for the Statewide supplemental payment.

(15) Repeal Department payments to MCOs to support HIPAA compliance and define the payment rate methodology for new Medicaid managed care enrollees.

(16) Amend the MCO per visit medical and dental reimbursement rates for Federally Qualified Health Centers (FQHCs).

(17) Revise the enhanced dental plan regulation to only reflect the utilization target for calendar year 2004.

(18) Amend the time period that MCOs can terminate their agreement with the Department to participate in the HealthChoice Program.

(19) Clarify that MCOs are required to ensure medical appointments are scheduled for their enrollees.

(20) Add new regulations that require the MCOs to meet certain specialty provider network requirements.

(21) Remove clinical and pharmacy access language that was relevant to the first six months of the HealthChoice Program.

(22) Ensure that the criteria providers are required to use during their substance abuse placement appraisals is consistent throughout the regulation.

(23) Clarify that MCOs are responsible for the payment of any durable medical equipment authorized for enrollees even if delivery of the item occurs within 90 days after the member's disenrollment from the MCO, as long as the member remains Medicaid eligible during the 90-day time period.

(24) Amend benefits limitation language to clarify that the Department is responsible for the purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers.

(25) Amend benefits limitation language to clarify that the Department is responsible for the new prescription drug enfuvirtide, which is used to treat HIV/AIDS.

(26) Allow MCOs to establish corrective managed care programs for individuals determined to have abused MCO benefits.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The rate changes will have a negative economic impact on the Department and positive impact on the MCOs and their sub-contracted providers.

II. Types of Economic Impact.	Revenue (R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency:	(E+)	$71,264,031
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Benefit (+) Cost (–)	Magnitude
D. On regulated industries or trade groups:	(+)	$71,264,031
E. On other industries or trade groups:	(+)	Undeterminable
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. The Department's projected January — December 2004 expenditure will increase by 5.3 percent on an MCO base of approximately $1,300,000,000 due to the increase in rates paid to the MCOs. Funding for the trauma supplemental payments to MCOs is included in COMAR 10.25.10.

D. There will be a positive impact on the MCOs due to the MCO rate increase.

E. The impact of this increase on the MCO subcontracted provider is unknown.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Regulations Coordinator, Department of Health and Mental Hygiene, Room 521, 201 West Preston Street, Baltimore, Maryland 21201, or fax to (410) 333-7687, or email to regs@dhmh.state.md.us, or call (410) 767-6499, or 1-877-4MD-DHMH, extension 6499. These comments must be received by November 3, 2003.

10.09.62 Maryland Medicaid Managed Care Program: Definitions

Authority: Health-General Article, §15-101, Annotated Code of Maryland

.01 Definitions.

A. Except as expressly limited, in COMAR 10.09.62 — [10.09.74] *10.09.75* the following terms have the meanings indicated.

B. Terms Defined.

(1) — (18) (text unchanged)

(19) ["C.A.G.E." means a mnemonic device that assists providers to screen for substance abuse.] *Repealed.*

(19-1) — (67) (text unchanged)

(68) "Health care [services] *service*" has the meaning stated in Health-General Article, [§19-501(f)] *§19-132*, Annotated Code of Maryland.

(69) — (74) (text unchanged)

(75) "Historic provider" means a health care provider, as defined in Health-General Article, [§19-150.1] *§19-132*, or a residential service agency, as defined in Health-General Article, §19-4A-01, Annotated Code of Maryland, who, on or before June 30, 1995, had a demonstrated history of providing health care services to Program recipients and otherwise meets the requirements of COMAR 10.09.65.16.

(76) — (102) (text unchanged)

(103) ["Michigan Alcohol Screening Test (MAST)" means an instrument used to screen for alcohol abuse.] *Repealed.*

(104) — (107) (text unchanged)

(108) "Medically appropriate" means an effective service that, *with respect to enrollees who are 21 years old or older,* can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any alternative services which could be used for the same purpose.

(109) — (125) (text unchanged)

(126) "Nursing facility" [means a skilled nursing facility as defined] *has the meaning stated* in COMAR 10.09.10.01B [or an intermediate care facility as defined in COMAR 10.09.11.01B].

(127) — (155) (text unchanged)

(156) "Provider" has the same meaning as "health care provider", as stated in Health-General Article, [§19-1501(d)] *§19-132*, Annotated Code of Maryland.

(157) — (204) (text unchanged)

10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment

Authority: Health-General Article, Annotated Code of Maryland

Regulations	Sections
.01	15-103(b)(3), (4), (5)
.02	15-103(b)(16)

.01 Eligibility.

A. — B. (text unchanged)

C. Duration. A recipient eligible for the Maryland Medicaid Managed Care Program is guaranteed Medicaid eligibility for a period of 6 months from the initial effective date of each Medicaid eligibility period in any eligibility category, with the exception of:

(1) (text unchanged)

(2) Individuals who possess private health insurance or obtain health insurance through another source; [and]

(3) Inmates of public institutions[.]*; and*

(4) Children younger than 19 years old with income greater than 185 percent but less than 300 percent of federal poverty level enrolled in Maryland Children's Health Program.

.02 Enrollment.

A. — G. (text unchanged)

H. Automatic Assignment Criteria.

(1) (text unchanged)

(2) Except as provided in §H(1) of this regulation, an eligible recipient who fails to elect an MCO within 21 days of the Department's mailing of eligibility notification shall be assigned to an MCO with available capacity that accepts new enrollees as follows:

(a) Unless inconsistent with assigning household members to the same MCO pursuant to §H(2)(b) of this regulation, the Department shall randomly assign the recipient to [an MCO in the local access area that provides adult dental benefits, or, if there are none, then randomly to] any MCO in the local access area; or

(b) (text unchanged)

I. — L. (text unchanged)

10.09.64 Maryland Medicaid Managed Care Program: MCO Application

Authority: Health-General Article, §§15-102 and 15-103, Annotated Code of Maryland

.03 Organization, Operations, and Financing.

Except as provided in Regulation .02B of this chapter, an MCO applicant shall include the following information or descriptions in its application:

A. — G. (text unchanged)

H. [A certificate of compliance] *Evidence of compliance with Maryland Workers' Compensation Law, as follows:*

(1) Except as provided in §H(2) of this regulation, the applicant shall submit:

(a) The policy number of its Workers' Compensation insurance coverage; and

(b) The name of its Workers' Compensation insurance carrier; or

(2) If self-insured, the applicant shall submit a certificate of compliance evidencing employee coverage under Workers' Compensation Law, as provided in Labor and Employment Article, Title 9, Annotated Code of Maryland;

I. — T. (text unchanged)

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Health-General Article,
Annotated Code of Maryland

Regulations	Sections
.02	15-102.4(a)(i)
.03	15-103(b)
.10	15-103(b)(10)
.15	15-103(b)(9)(ii)—(xiii)
.19 — .19-3	15-103b
[.19-4	15-103b]
.21	15-103(e)
.24	15-103(b)(2)(v), 12-103(c)(3)
.26	15-103(f)(5)(i)(2),A.,C.(3)

.02 Conditions for Participation.

A. — J. (text unchanged)

K. [When an MCO decides to temporarily stop accepting new enrollees, the MCO shall:

(1) Provide the Department with written notice at least 60 days before the day it will stop accepting new enrollees;] *MCO Local Access Area Participation.*

(1) The MCO shall provide written notification to the Department of the MCO's intent to participate and accept new enrollees in each of the local access areas by October 1 for the next calendar year.

(2) The MCO's decision to accept new enrollees is in effect from January 1 to December 31 unless the Department decides there is adequate justification to waive this requirement, which includes, but is not limited to, a rate cut or an MCO exit from the market.

(3) If the MCO has not participated in a local access area for a period of 12 or more consecutive months, the MCO may participate and accept new enrollees in that local access area by notifying the Department at least 30 days before accepting new enrollees.

(4) If system modifications require longer than 30 days to implement, the effective date may be extended.

(5) The MCO shall follow the access standards specified in COMAR 10.09.66.06 and .05-1.

L. In local access areas where the MCO decides to stop accepting new enrollees, the MCO shall:

[(2)] *(1)* — [(4)] *(3)* (text unchanged)

[L.] *M.* — [Q.] *R.* (text unchanged)

[R.] *S.* An MCO shall promptly *but within 30 calendar days of the suspected fraud* report to the Medicaid Fraud Control unit all suspected fraud and abuse, including fraud by employees and subcontractors of the MCO, enrollment agents, and recipients.

[S.] *T.* — [W.] *X.* (text unchanged)

.03 Quality Assessment and Improvement.

A. An MCO shall have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees including individuals with special health care needs. At a minimum, the [program] *MCO* shall:

(1) — (3) (text unchanged)

B. — C. (text unchanged)

.05 Special Needs Populations — Children with Special Health Care Needs.

A. — G. (text unchanged)

H. An MCO shall establish protocols for effecting medically necessary [and appropriate] service referrals to specialty care providers for children with special health care needs.

I. — K. (text unchanged)

.10 Special Needs Populations — Individuals with HIV/AIDS.

A. (text unchanged)

B. HIV/AIDS Specialist.

(1) An MCO shall allow an enrollee with HIV/AIDS to choose an HIV/AIDS specialist for treatment and coordination of primary and specialty care.

(2) To qualify as an HIV/AIDS specialist, a health care provider shall be board certified in the field if infectious diseases by a member board of the American Board of Medical Specialties or:

(a) Hold a current, valid, unrevoked, and unsuspended Maryland license as a:

(i) Doctor of medicine;

(ii) Doctor of osteopathy; or

(iii) Nurse practitioner;

(b) Have provided direct, continuous, ongoing care for at least 20 patients with HIV over the past 2 years; and

(c) Have completed one of the following requirements:

(i) If a medical doctor or doctor of osteopathy, at least 30 hours of HIV-related continuing medical education category I credits over the past 2 years;

(ii) If a nurse practitioner, at least 30 hours of HIV—related continuing education units over the past 2 years; or

(iii) If a medical doctor, doctor of osteopathy, or a nurse practitioner, an accredited training program over the past year.

[B.] *C.* — [E.] *F.* (text unchanged)

.15 Data Collection and Reporting.

A. — B. (text unchanged)

C. Monthly Reports.

(1) — (2) (text unchanged)

[(3) An MCO shall include with its update of the PCP's assigned enrollees the consent forms that it has received in the last 30 days from local department of social services offices, authorizing disclosure of confidential alcohol or drug treatment information and signed by the PCP's enrollees.]

(3) Within 10 calendar days after the close of each calendar month, an MCO shall submit a list of all preservice denials or reduction of services or benefits issued by the MCO or MCO subcontractors during the preceding month, which shall include for each recipient:

(a) Name;

(b) Medical assistance number;

(c) Date of denial or reduction of services;

(d) Service or benefit denied or reduced;

(e) Reason for denial or reduction of services;

(f) Date of denial or reduction of services letter; and

(g) An indication of review by the MCO Medical Director.

D. Quarterly Reports.

[(1)] An MCO shall submit to the Department:

[(a)] *(1)* Within 30 calendar days of the close of each calendar quarter, quality assurance reports including, but not limited to:

[(i)] *(a)* Quality assurance committee meeting minutes reflecting major quality assurance corrective action plans, initiatives, and activities[,]*; and*

[(ii) Complaint and grievance logs, including emergency room complaints or grievances, and

(iii) Resolutions of all complaints and grievances;]

(b) An analysis of recipient complaint logs including significant trends or anomalies, what caused the trend or anomaly, and any actions taken to address the trend or anomaly;

[(b)] *(2)* Within 30 calendar days of the close of each calendar quarter, third-party liability collection activities as described in Regulation .18D of this chapter.

E. Annual Reports. Except as provided in §E(5) of this regulation, an MCO shall submit to the Department annually, within 90 days after the end of the calendar year:

(1) A summary of the information contained in [§D(1)(b) and (c)] *§D(1)(b)* of this regulation;

(2) — (5) (text unchanged)

F. (text unchanged)

[G. An MCO shall, on the first business day of each calendar year, submit to the Department an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) report (Form HCFA-416).]

[H.] *G.* — [L.] *K.* (text unchanged)

.17 Subcontractual Relationships.

A. — B. (text unchanged)

C. Effect of Subcontract.

(1) (text unchanged)

(2) By entering into a subcontract to provide health care services on behalf of an MCO, the subcontracting provider becomes responsible for providing the specified health care services in compliance with all of the requirements imposed by COMAR 10.09.62 — [10.09.73] *10.09.75*, including, but not limited to, requirements concerning access, quality assurance, medical records, and reporting requirements.

(3) When entering into a subcontract to transfer to the subcontracting provider the initial responsibility for providing specified health care services to the MCO's enrollees, an MCO retains a primary duty to the Department and to its enrollees to ensure that its subcontractor delivers the required services in a manner that is consistent with the requirements of COMAR 10.09.62 — [10.09.73] *10.09.75*.

D. — E. (text unchanged)

.18-1 MCO Reimbursement — GME Exclusion.

A. Capitation Rate Setting Methodology — Extraction of Graduate Medical Education Costs.

(1) Percentage of Teaching Hospitals' Rates Representing GME Costs. The Department, in consultation with the HSCRC, shall:

(a) Determine the amount, expressed as a percentage, of payments by the Program that are attributable to GME, based on historic cost and discharge abstract data that:

(i) (text unchanged)

(ii) Are specific to Program recipients who would have been MCO-eligible if COMAR 10.09.62 — [10.09.74] *10.09.75* had been in effect at the time the activity reflected in the data occurred,

(iii) — (iv) (text unchanged)

(b) (text unchanged)

(2) — (5) (text unchanged)

B. (text unchanged)

.19 MCO Reimbursement.

A. Generally.

(1) (text unchanged)

(2) An MCO shall be reimbursed at rates set forth in this regulation only for individuals enrolled under the [HealthChoice Managed Care Program] *Maryland Medicaid Managed Care Program.*

(3) — (6) (text unchanged)

B. Capitation Rate-Setting Methodology.

(1) — (3) (text unchanged)

(4) The Department shall make capitation payments monthly at the rates specified in the following tables:

(a) — (b) (tables proposed for repeal)

(a) Rate Table for Families and Children. Effective January 1, 2004 — December 31, 2004.

Demographic Cells	*Age*	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
	Under Age 1	*Both*	*$290.10*	*$238.64*
	1 — 5	*Male*	*$142.64*	*$117.34*
		Female	*$123.70*	*$101.75*
	6 — 14	*Male*	*$90.03*	*$74.06*
		Female	*$80.09*	*$65.88*
	15 — 20	*Male*	*$108.14*	*$88.95*
		Female	*$183.37*	*$150.84*
	21 — 44	*Male*	*$298.45*	*$245.50*
		Female	*$276.33*	*$227.31*
	45 — 64	*Male*	*$814.98*	*$670.40*
		Female	*$575.62*	*$473.50*
ACG-adjusted cells ACG 100, 200, 300, 500, 600, 1100, 1600, 2000, 2400, 3400, 5110, 5200	*RAC1*	*Both*	*$78.35*	*$66.88*
ACG 400, 700, 900, 1000, 1200, 1300, 1710, 1800, 1900, 2100, 2200, 2300, 2800, 2900, 3000, 3100, 5310	*RAC2*	*Both*	*$104.77*	*$89.44*

Demographic Cells	*Age*	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
ACG 1720, 1730, 2500, 3200, 3300, 3500, 3800, 4210, 5320, 5339	*RAC3*	*Both*	*$131.83*	*$112.54*
ACG 800, 1740, 1750, 2700, 3600, 3700, 3900, 4000, 4100, 4220, 4310, 4410, 4510, 4610, 4710, 4720, 4810, 5340	*RAC4*	*Both*	*$220.97*	*$188.63*
ACG 1400, 1500, 1760, 1770, 2600, 4320, 4520, 4620, 4820	*RAC5*	*Both*	*$300.45*	*$256.49*
ACG 4330, 4420, 4830, 4910, 4920, 5010, 5020, 5040	*RAC6*	*Both*	*$491.86*	*$419.89*
ACG 4430, 4730, 4930, 5030, 5050	*RAC7*	*Both*	*$629.11*	*$537.05*
ACG 4940, 5060	*RAC8*	*Both*	*$963.99*	*$822.92*
ACG 5070	*RAC9*	*Both*	*$1,435.18*	*$1,225.17*
SOBRA Mothers			*$516.11*	*$424.55*
Delivery/Newborn			*$11,040.17*	*$9,081.56*
Persons with HIV	*All*	*Both*	*$648.59*	*$648.59*

(b) Rate Table for Disabled Individuals. January 1, 2004 — December 31, 2004.

Demographic Cells	*Age*	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
	Under Age 1	*Both*	*$1,789.47*	*$1,789.47*
	1 — 5	*Male*	*$609.13*	*$609.13*
		Female	*$655.96*	*$655.96*
	6 — 14	*Male*	*$214.74*	*$214.74*
		Female	*$296.74*	*$296.74*
	15 — 20	*Male*	*$287.89*	*$287.89*
		Female	*$322.19*	*$322.19*
	21 — 44	*Male*	*$928.11*	*$763.45*
		Female	*$937.10*	*$770.85*
	45 — 64	*Male*	*$1,195.12*	*$983.09*
		Female	*$1,155.52*	*$950.52*
ACG-adjusted cells				
ACG 100, 200, 300, 1100, 1300, 1400, 1500, 1600, 1710, 1720, 1730, 1900, 2400, 2600, 2900, 3400, 5110, 5200, 5310	*RAC10*	*Both*	*$211.79*	*$180.80*
ACG 400, 500, 700, 900, 1000, 1200, 1740, 1750, 1800, 2000, 2100, 2200, 2300, 2500, 2700, 2800, 3000, 3100, 3200, 3300, 3500, 3900, 4000, 4310, 5330	*RAC11*	*Both*	*$319.75*	*$272.96*
ACG 600, 1760, 3600, 3700, 4100, 4320, 4410, 4710, 4810, 4820	*RAC12*	*Both*	*$592.36*	*$505.68*
ACG 3800, 4210, 4220, 4330, 4420, 4720, 4910, 5320	*RAC13*	*Both*	*$691.23*	*$590.08*
ACG 800, 4430, 4510, 4610, 5040, 5340	*RAC14*	*Both*	*$917.08*	*$782.88*
ACG 1770, 4520, 4620, 4830, 4920, 5050	*RAC15*	*Both*	*$1,047.76*	*$894.44*
ACG 4730, 4930, 5010	*RAC16*	*Both*	*$1,350.16*	*$1,152.59*
ACG 4920, 5020, 5060	*RAC17*	*Both*	*$1,839.97*	*$1,570.72*
ACG 5030, 5070	*RAC18*	*Both*	*$2,415.02*	*$2,061.62*
Persons with AIDS	*All*	*Both*	*$2,951.29*	*$2,630.98*
Persons with HIV	*All*	*Both*	*$1,704.63*	*$1,704.63*

(c) — (e) (text unchanged)

(5) (text unchanged)

C. (text unchanged)

D. Interim Rates Adjustments.

(1) — (4) (text unchanged)

(5) The Department shall make supplemental payments to an MCO that reflect increases in MCO provider payments for trauma services described in COMAR 10.25.10.

.19-3 MCO Statewide Supplemental Payment.

A. On the payment dates specified in §B of this regulation, the Department shall make a Statewide supplemental payment to any MCO that has been approved for participation and has decided to operate without restricted enrollment in [each of] *all local access areas within* at least 20 of the 24 State jurisdictions.

B. MCOs are eligible to receive a supplemental payment or payments if the following conditions are met:

(1) June [2003] *2004* payment:

(a) (text unchanged)

(b) The qualifications in §A of this regulation were met from January 1 through June 30, [2003] *2004*; and

(2) December [2003] *2004* payments:

(a) (text unchanged)

(b) The qualifications in §A of this regulation were met from July 1 through December 31, [2003] *2004*.

C. The June [2003] *2004* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in May [2003] *2004* prospectively for that MCO's June [2003] *2004* enrollment, multiplied by $10.21 per enrollee.

D. The December [2003] *2004* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in November [2003] *2004* prospectively for that MCO's December [2003] *2004* enrollment, multiplied by $10.21 per enrollee.

.19-4 MCO-Specific Case Mix Adjustment.

A. Definitions.

(1) In this regulation, in addition to the definitions set forth in COMAR 10.09.62, the following terms have the meanings indicated.

(2) Terms Defined.

(a) "Demographic rate cell" means a cell in one of the rates tables in Regulation .19B(4) of this chapter to which an MCO's enrollees are assigned pursuant to Regulation .19B(1)(b) and B(2)(b) of this chapter.

(b) "Initial rate adjustment period" means the 6-month period beginning January 1 of the rate year.

(c) "Mid-year rate adjustment period" means the 6-month period beginning July 1 of the rate year.

(d) "RAC rate cell" means a cell in one of the rates tables in Regulation .19B(4) of this chapter to which an MCO's enrollees are assigned pursuant to Regulation .19B(1)(a) and (2)(a) of this chapter.

(e) "Rate adjustment period" means a 6-month period within the rate year that includes:

(i) The initial rate adjustment period beginning January 1 of the rate year; and

(ii) The mid-year rate adjustment period beginning July 1 of the rate year.

(f) "Rate year" means the calendar year to which the rates calculated pursuant to this regulation apply.

(g) "Risk Adjustment Category (RAC)" means a grouping of adjusted clinical groups (ACGs), each of which is associated with a similar level of risk.

(h) "Risk assessment cohort" means each of the eight groupings of enrollees, assigned on the basis of their:

(i) Program eligibility category, either "families and children", as specified in Regulation .19B(1) of this chapter, or "disabled", as specified in Regulation .19B(2) of this chapter;

(ii) Region of residence category, either in "Baltimore City" or in the "rest of State"; and

(iii) Age category, either at least 1 year old but younger than 21 years old, or 21 years old or older.

(i) "Risk assessment year" means the calendar year 2 years before the rate year.

B. For calculating an adjustment to MCO payment rates reflecting the relative level of risk of providing enrollees assigned to demographic rate cells covered health care services pursuant to COMAR 10.09.67, the Department shall, for each MCO, identify the enrollees to be considered as follows:

(1) For each rate adjustment period in the rate year, identify the current demographic enrollees for each MCO who:

(a) In the risk assessment year:

(i) Were certified eligible for the Program for at least 6 months;

(ii) Were assigned to a demographic rate cell; and

(iii) As of June 30, were 1 year old or older; and

(b) In the calendar year before the rate year:

(i) For the initial rate adjustment period calculation for the rate year 2004, were enrolled in the MCO in March;

(ii) For the initial rate adjustment period calculation for rate years after 2004, were enrolled in the MCO in June; and

(iii) For the mid-year rate adjustment period calculation, were enrolled in the MCO in December;

(2) Assign each enrollee identified pursuant to §B(1) of this regulation into one of the eight risk assessment cohorts;

(3) Make the determinations necessary for the assignments required by §B(2) of this regulation consistent with the following time frames:

(a) For an initial rate adjustment period calculation for the rate year 2004:

(i) An enrollee's eligibility category and region of residence as of March of the calendar year before the rate year; and

(ii) An enrollee's age category as of March 31 of the calendar year before the rate year;

(b) For an initial rate adjustment period calculation for rate years after 2004:

(i) An enrollee's eligibility category and region of residence as of June of the calendar year before the rate year; and

(ii) An enrollee's age category as of June 30 of the calendar year before the rate year; and

(c) For a mid-year rate adjustment period calculation:

(i) An enrollee's eligibility category and region of residence as of December of the calendar year before the rate year; and

(ii) An enrollee's age category as of December 31 of the calendar year before the rate year; and

(4) For calculating an MCO's case mix adjustment pursuant to this regulation, disregard any risk assessment cohorts to which fewer than 50 of an MCO's enrollees are assigned pursuant to §B(2) of this regulation.

C. Methodology for Determining MCO-specific RAC Case Mix Measures. For each MCO, the Department shall:

(1) Based on encounter and fee-for-service data documenting services delivered during the risk assessment year, determine the diagnoses attributable to an MCO's enrollees identified pursuant to §B of this regulation;

(2) Based on diagnoses in the risk assessment year, assign each enrollee identified pursuant to §B of this regulation to the appropriate risk adjustment category (RAC), consistent with the protocol set forth in Regulation .19B(1)(a) and (2)(a) of this chapter;

(3) Apply the RAC rates for the appropriate rate adjustment period to the RAC distribution determined pursuant to §C(2) of this regulation;

(4) Using the results of the calculations specified in §C(3) of this regulation, calculate an MCO's average RAC rates separately for each of the MCO's risk assessment cohorts derived in accordance with §B of this regulation; and

(5) To determine an MCO's relative RAC case mix factors, divide each of the MCO's average RAC rates determined in accordance with §C(4) of this regulation by each overall average RAC rate for all MCOs for the same risk assessment cohort.

D. Methodology for Determining MCO-specific Demographic Case Mix Measures. For each MCO, the Department shall:

(1) Determine the demographic distribution of its current enrollees as specified in §B of this regulation;

(2) Apply the appropriate demographic rates for the rate adjustment period to the demographic distribution as determined pursuant to §D(1) of this regulation;

(3) Using the results of the calculations specified in §D(2) of this regulation, calculate the MCO's average demographic rates separately for each of the MCO's risk assessment cohorts derived in accordance with §B of this regulation; and

(4) To determine an MCO's relative demographic case mix factors, divide each of the MCO's average demographic rates determined pursuant to §D(3) of this regulation by each of the overall average of demographic rates for all MCOs for the same risk assessment cohort.

E. MCO-Specific Case Mix Adjusted Demographic Rates. The Department shall, for each MCO:

(1) Calculate MCO-specific risk adjustment factors by dividing, for each risk assessment cohort, the relative RAC case mix factor determined pursuant to §C of this regulation, by the relative demographic case mix factor determined pursuant to §D of this regulation;

(2) Modify the MCO-specific risk adjustment factor derived for each risk assessment cohort pursuant to §E(1) of this regulation as follows:

(a) Reduce each risk adjustment factor that is higher than 1.1 to 1.1; and

(b) Increase each risk adjustment factor that is lower than 0.9 to 0.9;

(3) Subject to §E(4) of this regulation, calculate the MCO-specific demographic rates for the rate adjustment period by multiplying the risk adjustment factor for each risk assessment cohort, derived pursuant to §E(1) of this regulation, by the value specified in each demographic rate cell for the rate year; and

(4) Apply a budget neutrality adjustment to the values derived in §E(3) of this regulation so that aggregate payments to all MCOs pursuant to this regulation are equivalent to the aggregate payments that would be due to all MCOs in the absence of this regulation.

F. Case Mix Updates. The Department shall:

(1) Repeat the calculations described in §§C — E of this regulation every 6 months to update current MCO enrollees' region of residence, age, and enrollment categories as of the calendar year before the rate year, as provided in §B(3) of this regulation; and

(2) For the rate adjustment periods beginning January 1 and July 1 of each rate year, use each MCO's updated RAC case mix measures and updated demographic case mix measures to compute its demographic rates for the rate adjustment period, as described in §E of this regulation.

.21 Payments to Federally Qualified Health Centers (FQHC).

A. Effective January 1, [2003] *2004*, an MCO shall reimburse an FQHC with which it subcontracts at least [$61.55] *$63.11* per visit for Medicaid covered services other than dental services.

B. Effective January 1, [2003] *2004*, an MCO shall reimburse an FQHC with which it subcontracts at least [$15.96] *$16.28* per visit for dental services to recipients younger than 21 years old and to pregnant women.

C. — E. (text unchanged)

.24 Enhanced Dental Services Plan.

A. By January 1 of each year, an MCO shall submit an enhanced dental services plan in a format specified by the Department.

B. For calendar year 2004, an MCO shall set a goal to provide dental services to 70 percent of enrollees who are younger than 21 years old.

C. An MCO shall meet a minimum compliance rate of providing dental services to 40 percent of enrollees who are younger than 21 years old.

.26 Time Period for Termination of Provider Agreement.

A. An MCO may terminate its provider agreement with the State [after providing the Department with written notice of its intent to terminate, at least 120 days before the intended date of termination.] *as provided in §§B — D of this regulation.*

B. [An MCO may terminate its provider agreement with the State after providing the Department 90 days notice before the intended date of termination if the notice is provided by October 1.] *The MCO shall provide written notification to the Department of the MCO's intent to terminate the MCO's provider agreement with the State for any given calendar year by the previous October 1.*

C. An MCO that has previously terminated the provider agreement with the State and would like to sign a new agreement with the State, shall follow the application process as specified under COMAR 10.09.64.

D. The Department may waive the requirement under §B of this regulation if the Department determines that the circumstances warrant, including but not limited to a reduction in rates outside the normal rate setting process or an MCO exit from the program.

10.09.66 Maryland Medicaid Managed Care Program: Access

Authority: Health-General Article,
Annotated Code of Maryland

Regulations	Sections
.03	15-103(b)
.05-1	*15-102.1(b)(10) and 15-103(b)*
.07	15-103(b)(2)

.03 Access Standards: Outreach.

A. — B. (text unchanged)

C. Adults.

(1) An MCO shall, before referring the enrollee to the local health department, make documented attempts to [schedule] *ensure that* follow-up appointments are scheduled in accordance with the enrollee's treatment plan by attempting a variety of contact methods, which may include:

(a) — (c) (text unchanged)

(2) (text unchanged)

D. Child Younger than 2 Years Old Needing EPSDT Screening Services.

(1) An MCO shall [schedule] *ensure that* appointments *are scheduled* in accordance with the EPSDT periodicity schedule or within 30 days of the MCO's receipt of the health risk assessment, whichever is less.

(2) If the enrollee fails to keep the appointment, the MCO shall [schedule] *ensure that* a second appointment *is scheduled* within 30 days.

(3) — (6) (text unchanged)

E. Child Younger than 21 Years Old Needing Follow-up Treatment.

(1) An MCO shall [schedule] *ensure that* an appointment for follow-up care *is scheduled* at a time interval appropriate to the enrollee's diagnosed condition.

(2) — (5) (text unchanged)

F. Pregnant or Postpartum Woman Needing Prenatal or Postpartum Care.

(1) (text unchanged)

(2) Follow-Up Appointments. After the enrollee has completed an initial visit that includes a comprehensive history, physical exam, and completion of the Maryland Prenatal Risk Assessment, the MCO shall [schedule] *ensure that* appointments *are scheduled* for the enrollee in compliance with the periodicity schedule of the ACOG guidelines. If the enrollee fails to appear for a scheduled appointment, the MCO shall [reschedule] *ensure that the appointment is rescheduled for* the enrollee to be seen within 10 days.

(3) — (5) (text unchanged)

.05-1 Access Standards: Specialty Provider Network.

A. Standards and Regions.

(1) The Department shall review an MCO's specialty provider network for MCO's overall network and for each region as defined in §A(4) of this regulation.

(2) Overall Network Standard.

(a) An MCO shall contract with at least one provider in each of the 14 major specialty areas specified in §A(2)(b) of this regulation.

(b) The 14 major specialties are:

(i) Allergy;
(ii) Cardiology;
(iii) Dermatology;
(iv) Endocrinology;
(v) Otolaryngology (ENT);
(vi) Gastroenterology;
(vii) Infectious disease;
(viii) Nephrology;
(ix) Neurology;
(x) Ophthalmology;
(xi) Orthopedics;
(xii) Pulmonology;
(xiii) Surgery; and
(xiv) Urology.

(3) Regional Network Standards.

(a) For each of the specialty care regions listed in §A(4) of this regulation that an MCO serves, an MCO shall contract with at least one provider in each of the eight core specialties specified in §A(3)(b) of this regulation in each region the MCO serves.

(b) The 8 core specialties are:

(i) Cardiology;
(ii) Otolaryngology (ENT);
(iii) Gastroenterology;
(iv) Neurology;
(v) Ophthalmology;
(vi) Orthopedics;
(vii) Surgery; and
(viii) Urology.

(4) Specialty Care Regions. The 40 local areas established by COMAR 10.09.66.06E are grouped into 10 mutually exclusive specialty care regions as follows:

Region	*Local Access Area*
1	*Allegany, Garrett, Washington*
2	*Anne Arundel North, Anne Arundel South, Howard*
3	*Carroll, Harford East, Harford West, Baltimore County North*
4	*Baltimore City — SE/Dundalk, Baltimore City — East, Baltimore City — North Central, Baltimore City Northeast, Baltimore County East*
5	*Baltimore City — Northwest, Baltimore County Northwest, Baltimore City — South, Baltimore City — West, Baltimore County Southwest*
6	*Montgomery — Silver Spring, Montgomery — Midcounty, Montgomery — North, Frederick*
7	*Prince George's Northeast, Prince George's Northwest, Prince George's Southeast, Prince George's Southwest*
8	*Calvert, Charles, St. Mary's*
9	*Caroline, Kent, Queen Anne's, Talbot, Cecil*
10	*Dorchester, Somerset, Wicomico, Worcester*

B. If the Department determines that an MCO does not meet the requirements specified in §A(2)(a) or (3)(a) of this regulation, the MCO may provide additional information to support the adequacy of the MCO's specialty network before any action is taken by the Department.

C. If an MCO fails to meet the requirements established by this regulation, the Department may suspend the automatic assignment to the MCO of recipients who live in the affected specialty care region. A suspension of automatic assignments may affect the MCO's ability to qualify for the statewide supplemental payments specified under COMAR 10.09.65.19-3.

.07 Access Standards: Clinical and Pharmacy Access.

A. Appointments.

(1) New Enrollees: Initial Appointment.

(a) (text unchanged)

(b) Unless the new enrollee is assigned to a PCP who was the enrollee's established provider of care immediately before the enrollee's enrollment, and, consistent with any applicable periodicity schedule, the PCP concludes that no immediate initial appointment is necessary:

(i) Unless a shorter time frame otherwise applies, the MCO shall [schedule] *ensure that* a new enrollee's initial appointment *is scheduled* to occur within 90 days of the date of enrollment;

(ii) Unless the PCP confirms that the enrollee has elected to continue prenatal care with her established provider pursuant to COMAR 10.09.67.28C, the MCO shall [schedule] *ensure that* an initial prenatal appointment *is scheduled* to occur within 10 days of the date that the MCO receives the enrollee's completed health risk assessment, or within 10 days of the enrollee's request for an appointment, whichever is sooner;

(iii) If the new enrollee is a person requesting family planning services, the MCO shall [schedule] *ensure that* an initial appointment *is scheduled* to occur within 10 days of the date of the enrollee's request for an appointment; or

(iv) If the new enrollee is identified to be at high risk by the health risk assessment, the MCO shall [schedule] *ensure that* an initial appointment *is scheduled* to occur within 15 business days of the MCO's receipt of the enrollee's completed health risk assessment.

(2) (text unchanged)

(3) Appointment Guidelines.

(a) (text unchanged)

(b) An MCO shall effect procedures that result in an interval between the enrollee's request for an appointment and the actual appointment time being consistent with the following standards:

(i) (text unchanged)

(ii) When §A(3)(b)(i) of this regulation does not apply, well-child assessments shall be scheduled to be completed within 30 days of the request for an appointment[,

except that, during the first 6 months following implementation of the Maryland Medicaid Managed Care Program, the 30-day time period may be extended, but may not exceed 60 days];

(iii) — (iv) (text unchanged)

(v) Requests for routine and preventative primary care appointments shall be scheduled to be performed within 30 days of the request[, except that, during the first 6 months following implementation of the Maryland Medicaid Managed Care Program, the 30-day time period may be extended, but may not exceed 60 day];

(vi) — (ix) (text unchanged)

B. — E. (text unchanged)

10.09.67 Maryland Medicaid Managed Care Program: Benefits

Authority: Health-General Article, §15-103(b)(2), Annotated Code of Maryland

.01 Required Benefits Package — In General.

A. (text unchanged)

B. Except for specialty mental health services, any limitations set forth in Regulation .27 of this chapter on covered services are not applicable to services required by enrollees who are younger than 21 years old when it is shown that the services are medically necessary [and appropriate] to correct or lessen health problems detected or suspected by EPSDT screening services, as described in Regulation .20 of this chapter.

C. — E. (text unchanged)

.06 Dental Services.

A. An MCO shall provide medically necessary [and appropriate] dental services for its enrollees who are younger than 21 years old, including but not limited to:

(1) — (4) (text unchanged)

(5) General anesthesia during dental procedures when it is medically necessary [and appropriate].

B. (text unchanged)

.10 Benefits — Substance Abuse Treatment Services.

A. An MCO shall provide to its enrollees medically necessary and appropriate comprehensive substance abuse treatment services in accordance with the standards set forth in COMAR 10.09.65.11 — .11-2, including but not limited to:

(1) Evaluations, performed by a provider that is qualified under §B of this regulation, to determine the nature and severity of an enrollee's substance abuse problem and the appropriate level and intensity of care, including:

(a) (text unchanged)

(b) A placement appraisal [which, as of October 1, 1998, shall be one using the ASAM PPC-2 placement criteria] *to determine, based on the current edition of the American Society of Addiction Medicine Patient Placement Criteria, or its equivalent as approved by the Alcohol and Drug Abuse Administration, the appropriate level and intensity of care for the enrollee;*

(2) — (6) (text unchanged)

B. — C. (text unchanged)

.13 Benefits — Disposable Medical Supplies and Durable Medical Equipment.

A. — C. (text unchanged)

D. An MCO is responsible for paying for any durable medical equipment authorized and ordered while the member is active with the MCO if:

(1) The delivery of the item occurs within 90 days after the member's termination date from the MCO; and

(2) The member remains a Medicaid recipient.

.14 Benefits — Vision Care Services.

A. — B. (text unchanged)

C. For its enrollees who are younger than 21 years old, the MCO is responsible for providing medically necessary [and appropriate] vision services, including but not limited to:

(1) — (2) (text unchanged)

(3) Contact lenses, if medically necessary [and appropriate] and if eyeglasses are not medically appropriate for the condition.

.20 Benefits — EPSDT Services.

A. An MCO shall provide, to enrollees younger than 21 years old, medically necessary [and appropriate] Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, including:

(1) — (3) (text unchanged)

B. — C. (text unchanged)

.27 Benefits — Limitations.

A. (text unchanged)

B. The benefits or services not required to be provided under §A of this regulation are as follows:

(1) — (33) (text unchanged)

(34) [For enrollees who are 21 years old and older, the] *The* purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers;

(35) — (38) (text unchanged)

(39) Genotypic, phenotypic, or other HIV/AIDS drug resistance testing used in the treatment of HIV/AIDS, the provision of which will be reimbursed directly by the Department if the service is:

(a) (text unchanged)

(b) Medically necessary and appropriate; [and]

(40) Except for those listed in Regulation .04D(4) of this chapter, drugs that are included in the SMHS formulary*; and*

(41) Payment to pharmacies for the drug enfuvirtide used in the treatment of HIV/AIDS, the provision of which will be reimbursed directly by the Department.

10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures

Authority: Health-General Article, [Title 15, Subtitle 1,] *§15-103(b)(i)(4)*, Annotated Code of Maryland

.02 Internal Grievance Process for Enrollees.

A. — B. (text unchanged)

C. An MCO shall include in the internal grievance process described in the written grievance procedures the procedures for registering and responding to complaints in a timely fashion, which:

(1) — (9) (text unchanged)

(10) Include a documented procedure for reporting of all [complaints]*:*

(a) Complaints received by the MCO to:

[(a)] *(i)* — [(c)] *(iii)* (text unchanged)

[(d)] *(iv)* The Department [on a monthly basis] *as requested*; and

(b) The quarterly complaint analysis performed by the MCO as specified in COMAR 10.09.65D(1)(a)(ii); and

(11) (text unchanged)

10.09.75 Maryland Medicaid Managed Care Program — Corrective Managed Care.

Authority: Health-General Article, §§15-102.1(b)(9) and 15-103, Annotated Code of Maryland

.01 Corrective Managed Care — General.

A. An enrollee determined to have abused MCO benefits shall be enrolled in corrective managed care developed and maintained by the MCO if the MCO elects to have a corrective managed care program.

B. Enrollee abuse exists if an enrollee:

(1) Utilizes an inappropriate type of provider for care;

(2) Utilizes an appropriate type of provider but at an inappropriate service rate;

(3) Utilizes an appropriate provider but distorts or fails to disclose pertinent medical information;

(4) Utilizes an MCO card in an inappropriate manner; or

(5) Engages in Medicaid fraud under COMAR 10.09.24.14.

.02 Procedures.

A. The MCO to which the enrollee is assigned shall determine if enrollee abuse exists using the procedures in Regulation .01B of this chapter.

B. Cases may be reviewed utilizing statistical reports, outside complaints, referrals from other agencies, or other appropriate sources.

C. If the alleged or noted behavior is one of the types listed in Regulation .01B of this chapter, all relevant and available information shall be forwarded to a medical professional employee of the MCO for medical review.

D. The medical reviewer shall consider all relevant and available information including MCO payment records and information secured from interviews, if conducted, in making a decision. If appropriate, the medical reviewer may obtain records from other sources, including providers of medical services.

E. An enrollee determined to have abused MCO benefits shall receive a written notice which includes the following:

(1) The reason or reasons why the enrollee was found to have abused benefits;

(2) A statement that the enrollee will be enrolled in corrective managed care and the effective date and duration of that enrollment; and

(3) A statement that the enrollee may identify a preference for an assigned primary medical care provider, specialty care provider, or pharmacy.

.03 Provider Selection.

A. If abuse has been determined, the MCO shall select primary care, specialty care, and pharmacy providers for recipients as provided in this regulation.

B. The primary care or specialty care provider may be any participating provider in the MCO that meets the requirements of COMAR 10.09.66.05A.

C. The pharmacy provider may be any pharmacy or any single branch of a pharmacy chain, which participates in the MCO and meets the requirements of COMAR 10.09.66.06C and .07C(2).

D. The enrollee may suggest primary care, specialty care, and pharmacy providers. However, the MCO is not bound by the enrollee's suggestion and may designate other providers if, in the MCO's sole discretion, the recipient's choice of provider would not serve the enrollee's best interest in achieving appropriate use of the health care systems and benefits available through the MCO.

E. The enrollee shall obtain prescribed drugs only from a single designated pharmacy provider, except in an emergency or pursuant to hospital inpatient treatment.

F. The MCO shall designate a new primary care, specialty care, or pharmacy provider if the:

(1) Enrollee moves out of the service area of the current primary care or pharmacy provider; or

(2) Provider currently selected refuses to serve as the enrollee's provider.

.04 Enrollment in Corrective Managed Care.

A. The decision to enroll the enrollee in corrective managed care and the designation of primary care, specialty care, and pharmacy providers is the responsibility of the MCO.

B. Procedural Requirements.

(1) Before implementing a corrective managed care program, the MCO shall submit the MCO's procedures to the Department for review and approval.

(2) After approval has been obtained, the MCO shall submit monthly a list of the enrollees who have been enrolled in the MCO's corrective managed care program.

(3) Any procedural change to the MCO's corrective managed care procedures shall be approved by the Department before implementation.

C. Enrollment Periods in Corrective Managed Care.

(1) The initial period of enrollment is 6 months.

(2) An enrollee who has completed the period of enrollment and who is subsequently found to have abused MCO benefits for a second time shall be enrolled for an additional 12 months.

(3) An enrollee who has been found on three separate determinations to abuse MCO benefits shall be enrolled for a period of 24 months.

(4) An enrollee found to have abused MCO benefits while enrolled in corrective managed care shall have the enrollment period extended for an additional 18 months.

D. Annual Right to Change.

(1) An enrollee who is enrolled in corrective managed care may select another MCO in accordance with COMAR 10.09.63.05 and .06A.

(2) An enrollee's new MCO may continue to place the enrollee in corrective managed care according to the time frame already established by the previous MCO and in accordance to §C of this regulation.

E. Enrollee Appeal.

(1) An individual placed into corrective managed care may appeal the decision as specified in COMAR 10.09.72.05.

(2) The MCO shall attend the hearing and provide justification for the corrective managed care enrollment.

NELSON J. SABATINI
Secretary of Health and Mental Hygiene