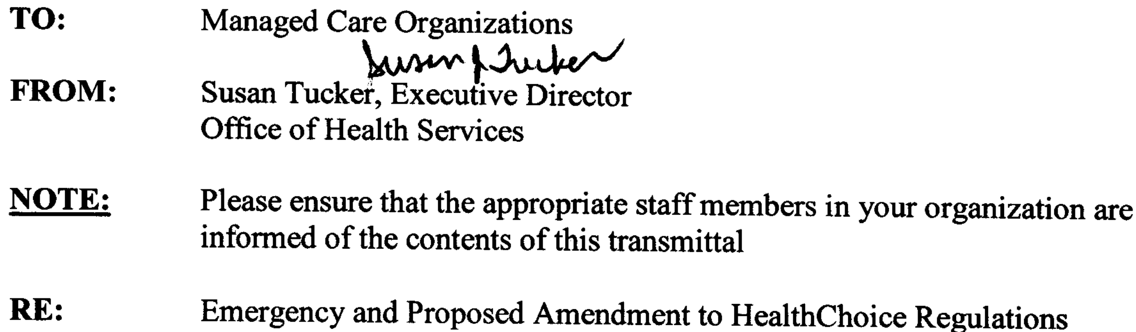
STATE OF MARYLAND
DHMH

PT 9-06
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 – S. Anthony McCann, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 60
August 12, 2005



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: Emergency and Proposed Amendment to HealthChoice Regulations

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ACTION:
Emergency Regulations
Proposed Regulations

EFFECTIVE DATE:
Requested July 1, 2005 effective date

WRITTEN COMMENTS TO:
Michelle 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:
James Gardner, Chief
Division of HealthChoice Management and Quality Assurance
(410) 767-1482 or call
1-877-4MD-DHMH extension 1482

COMMENT PERIOD EXPIRES: September 7, 2005

The Maryland Medical Assistance Program is promulgating emergency and proposed amendments to Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions; Regulations .03, .15 and 19 and adopt the new Regulation .19-5 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; and Regulation .01 under Comar 10.09.67 Maryland Medicaid Managed Care Program: Benefits.

The proposed amendments will:

(1) Revise regulations to include changes to Quality Assessment and Improvement definitions;

(2) Specify the core performance measures, and specify the incentive and disincentive methodology used by the Department with regards to MCO quality performance measures;

(3) Establish new MCO rates for the time period of July 2005 through December 2005;

(4) Add language establishing the Department's method for determining an MCO's loss ratio; and

(5) Adjust the co-payment for brand-name drugs.

A copy of the proposed amendments, as published in the August 5, 2005 issue of the Maryland Register, is attached.

attachment

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.02 Physicians' Services

Authority: Health-General Article, §§2-104(b) and 15-105, Annotated Code of Maryland

Notice of Proposed Action

[05-186-P-I]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.07** under **COMAR 10.09.02 Physicians' Services**.

Statement of Purpose

The purpose of this action is to revise the Maryland Medical Assistance Program's Physicians' Services Provider Fee Manual by incorporating the American Medical Association's Current Procedural Terminology (CPT) additions and deletions for 2005 and to increase the fees for over 1,500 surgical procedures for four medical specialties to approximately the Medicare rate.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The Maryland Health Care Provider Rate Stabilization Fund has allocated $5,368,692 ($2,684,346 in general funds, $2,684,346 in federal funds) to the Medical Assistance Program for FY 2006 to increase fee-for-service rates for procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians.

II. Types of Economic Impact.	Revenue ((R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency:	(E+)	$2,684,346 general $2,684,346 federal
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (−)	**Magnitude**
D. On regulated industries or trade groups:	(+)	$5,368,692
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

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

A. In order to retain health care providers in the State and assure access to quality health care Senate Bill 836 created a Medical Assistance Account which allocates funds to the Department of Health and Mental Hygiene to increase Medical Assistance fee-for-service rates for physicians in the specialties of obstetrics, neurosurgery, orthopedic surgery, and emergency medicine. The General Fund cost of the fee increases is $2,684,346 and $2,684,346 will be received from federal matching funds.

D. An increase in Medicaid reimbursement rates for fee-for-service providers in four specialties will cost $5,368,692 for fee-for-service in FY 2006. Over 1,500 procedures and services will have their rates increased to over 99 percent of the local Medicare fee schedule amount. It is assumed that reimbursing physicians at these higher rates will be an incentive for providers to continue to provide quality health care in the State.

Economic Impact on Small Businesses

The proposed action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

This action would have a meaningful impact on small businesses since certain physicians would receive increased reimbursement for services delivered to Medicaid patients.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, Room 521, 201 W. Preston Street, Baltimore, Maryland 21201, or call (410) 767-6499 or 1-877-4MD-DHMH, extension 6499, or fax to (410) 333-7687, or email to regs@dhmh.state.md.us. Comments will be accepted through September 7, 2005.

Editor's Note on Incorporation by Reference

Pursuant to State Government Article, §7-207, Annotated Code of Maryland, the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, Revision 2005 has been declared a document generally available to the public and appropriate for incorporation by reference. For this reason, it will not be printed in the Maryland Register or the Code of Maryland Regulations (COMAR). Copies of this document are filed in special public depositories located throughout the State. A list of these depositories was published in 32:2 Md. R. 128 (January 22, 2005) and is available online at www.dsd.state.md.us. The document may also be inspected at the office of the Division of State Documents, 16 Francis Street, Annapolis, Maryland 21401.

.07 Payment Procedures.

A. — C. (text unchanged)

D. The Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, Revision **[**2003**]** *2005*, is contained in the Medical Assistance Provider Fee Manual, dated October 1986. All the provisions of this document, unless specifically excepted, are incorporated by reference.

E. — Q. (text unchanged)

S. ANTHONY McCANN
Secretary of Health and Mental Hygiene

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[05-187-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 **.03**, **.15**, and **.19**, and adopt new Regulation **.19-5** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations**; and

(3) Amend Regulation **.01** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits.**

Statement of Purpose

The purposes of this action are to:

(1) Revise regulations to include changes to Quality Assessment and Improvement definitions;

(2) Specify the core performance measures, and to specify the Incentive and Disincentive methodology used by the Department with regards to Managed Care Organization (MCO) quality performance measures;

(3) Establish new MCO rates for the time period of July 2005 through December 2005;

(4) Establish the Department's method for determining an MCO's loss ratio; and

(5) Adjust the co-payment for brand-name drugs.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. There will be increased expenditure by the agency, which will increase the revenue of MCOs.

II. Types of Economic Impact.	Revenue (R+/R−) Expenditure (E+/E−)	Magnitude
A. On issuing agency:	(E+)	$8,675,022
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (−)	Magnitude
D. On regulated industries or trade groups:	(+)	$8,675,022
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

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

A. Rate increase of $8,675,022 is due to trend changes for inpatient and outpatient hospital, the physician fee increase, and also a 1 percent budget reduction.

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

Economic Impact on Small Businesses

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

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. Preston Street, Room 521, Baltimore, Maryland 21201, or call (410) 767-6499 or 1-877-4MD-DHMH, extension 6499, or fax to (410) 333-7687, or email to regs@dhmh.state.md.us. Comments will be accepted through September 6, 2005.

10.09.62 Maryland Medicaid Managed Care Program: Definitions

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

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) — (65) (text unchanged)

(65-1) "HealthChoice Financial Monitoring Report (HFMR)" means an annual financial report of an MCO's MMMCP-related activities during a specified calendar year that:

(a) Is submitted to the Department by an MCO pursuant to COMAR 10.09.65.15;

(b) Serves as a supplemental schedule to an MCO's quarterly and annual reports to the Maryland Insurance Administration; and

(c) Includes a completed HFMR form provided by the Department and any supplemental schedules required by the Department.

(66) — (97) (text unchanged)

(98) "Loss ratio" [has the meaning stated in COMAR 31.13.01.04B(15).] *means the ratio of an MCO's:*

(a) Net medical expenses plus medical management expenses which:

(i) Are quantified according to COMAR 10.09.65.19-5;

(ii) Relate solely to the MCO's MMMCP line of business; and

(iii) Are incurred during a specified period; and

(b) Net revenues which:

(i) Relate solely to the MCO's MMMCP line of business; and

(ii) Are earned during the same specified period in which the expenses referenced in §B(98)(a) of this regulation are incurred.

(99) — (100) (text unchanged)

(101) "Maryland Medicaid Managed Care Program *(MMMCP)*" means the Medicaid reform program established in this subtitle, as authorized by Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland, and by a §1115 waiver issued by the federal government.

(102) — (105) (text unchanged)

(105-1) "Medical expense" means costs incurred by an MCO in connection with providing health care services to its enrollees.

(105-2) "Medical management expense" means costs incurred by an MCO in connection with outreach and utilization management activities as specified in COMAR 10.09.65.19-5.

(106) — (122) (text unchanged)

(122-1) "Net medical expenses" means an MCO's total medical expenses less reinsurance recoveries.

(122-2) "Net revenues" means an MCO's total revenues less reinsurance premiums.

(123) — (179) (text unchanged)

(179-1) "Service year" in the context of COMAR 10.09.65.19-5, means the calendar year in which an MCO incurs the expenses reported pursuant to COMAR 10.09.65.15E(5)(c).

(180) — (202) (text unchanged)

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Insurance Article, [§15-112] *§15-605*;
Health-General Article, [Titles 15 and 19] *§§2-104 and 15-103*,
Annotated Code of Maryland

.03 Quality Assessment and Improvement.

A. (text unchanged)

B. An MCO shall participate in all quality assessment activities required by the Department in order to determine if the MCO is providing medically necessary [and appropriate] enrollee health care. [Effective January 1, 2002, these] *These* activities include, but are not limited to:

(1) — (2) (text unchanged)

(3) The annual collection and evaluation of a set of performance measures with targets as determined by the Department as follows:

(a) The composition of the *core* performance [measure] *measures* [set shall include measures from various required quality assessment activities described in this regulation and any other measure established by the Department in order to determine MCO performance in providing health care to enrollees] *is listed below:*

(i) Well child visits, ages 3 — 6;

(ii) Dental services for children ages 4 — 20;

(iii) Ambulatory care for Supplemental Security Income (SSI) adults;

(iv) Ambulatory care for Supplemental Security Income (SSI) children;

(v) Timeliness of prenatal care;

(vi) Cervical cancer screening for women ages 21 — 64;

(vii) Lead screening for children ages 12 — 23 months;

(viii) Diabetic eye exams;

(ix) Childhood immunization status — Combo 2;

(x) Practitioner turnover; and

(xi) Claims adjudication;

[(b) With a goal of continuous improvement, targets for each measure shall be based on the most recent available national benchmarking data, or if no national data exists, on the analysis of HealthChoice encounter data;]

[(c)] *(b)* — [(d)] *(c)* (text unchanged)

(d) Starting with the 2006 audit, the Department shall notify MCOs of its core set of performance measures and targets at least 3 months before the calendar year for which the MCOs will be held accountable for compliance with the performance measures;

(e) For 2005 care performance measures, as specified in §B(3)(a)(i) — (ix) of this regulation, the Department shall impose penalties, rewards, disincentives, or incentives, based on performance targets as determined by the Department utilizing the following methodology:

(i) There shall be three levels of performance;

(ii) Performance shall be evaluated separately for each measure, and the measures shall have equal weight;

(iii) If an MCO's scores on the measures identified in §B(3)(a)(i) — (ix) of this regulation do not meet the minimum target level, the MCO shall receive a monetary sanction as set by the Department proportionate to the size of the MCO and the number of points below the target;

(iv) If an MCO's scores on the measures identified in §B(3)(a)(i) — (ix) of this regulation are above the incentive target level, the MCO shall receive a monetary incentive as set by the Department proportionate to the size of the MCO and the number of points above the target;

(v) The point range between the minimum target and the incentive target shall be considered the neutral range and the MCO may not be penalized or rewarded if its performance falls in this range; and

(vi) The monetary incentives paid to the MCOs as described in §B(3)(e)(iv) of this regulation shall not exceed the total amount of the penalties described in §B(e)(iii) of this regulation that are collected from the MCOs;

(f) Effective January 1, 2006, the performance measures will be the 11 measures as stated in §B(3)(a) of this regulation;

(g) Starting with the 2006 performance measures, the Department shall implement the following methodology for imposing penalties and incentives:

(i) There shall be three levels of performance;

(ii) Performance shall be evaluated separately for each measure, and each measure shall have equal weight;

(iii) For any of the measures in §B(3)(a)(i) — (ix) of this regulation that the MCO does not meet the minimum target, as determined by the Department, a penalty of 1/9 of 1/2 percent of the total capitation amount paid to the MCO during that calendar year shall be collected;

(iv) For any of the measures in §B(3)(a)(i) — (ix) of this regulation that the MCO exceeds the incentive target, as determined by the Department, the MCO shall be paid an incentive payment of up to 1/9 of 1/2 percent of the total capitation paid to the MCO during that calendar year; and

(v) The total amount of the incentive payments as described in §B(3)(g)(ii) of this regulation paid to the MCOs each year cannot exceed the total amount of the penalties as described in §B(3)(g)(iii) of this regulation collected from the MCOs in that same year; and

(h) Any penalty or capitation adjustment imposed under this section shall be in accordance with Regulation .19-5 of this chapter.

(4) — (6) (text unchanged)

C. (text unchanged)

.15 Data Collection and Reporting.

A. — D. (text unchanged)

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) — (4) (text unchanged)

(5) HealthChoice Financial Monitoring Reports (HFMRs) [and], *including* any supplemental schedules required by the Department [in]:

(a) In the format required by the Department [according to the following schedule:];

(b) Prepared according to:

(i) The criteria, set forth in Regulation .19-5 of this chapter, for allocating MCO costs to HFMR expense categories; and

(ii) Reporting instructions provided by the Department for the HFMR form and any required supplemental schedules; and

(c) Submitted according to the following schedule:

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

F. — K. (text unchanged)

.19 MCO Reimbursement.

A. (text unchanged)

B. Capitation Rate-Setting Methodology.

(1) — (3) (text unchanged)

(4) Except in the extent of adjustments required by §D of this regulation, or by Regulations .19-1 — .19-4 of this

chapter, the Department shall make payments monthly at the rates specified in the following tables:

[(a) — (c)] (tables proposed for repeal)

(a) Rate Table for Families and Children. Effective July 1, 2005 — December 31, 2005.

Demographic Cells	*Age*	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
	Born in CY 05 Birth weight 1,500 grams or less	*Both*	*$3,842.35*	*$3,432.59*
	Born in CY 05 Birth weight over 1,500 grams	*Both*	*$346.81*	*$333.41*
	Born before CY 05			
	Under age 1	*Both*	*$284.65*	*$224.20*
	1 — 5	*Male*	*$166.30*	*$130.39*
		Female	*$148.39*	*$116.35*
	6 — 14	*Male*	*$97.47*	*$76.42*
		Female	*$86.99*	*$68.21*
	15 — 20	*Male*	*$115.70*	*$90.72*
		Female	*$198.05*	*$155.29*
	21 — 44	*Male*	*$348.06*	*$272.90*
		Female	*$345.62*	*$270.99*
	45 — 64	*Male*	*$914.50*	*$717.03*
		Female	*$721.26*	*$565.52*
ACG-adjusted cells				
ACG 100, 200, 300, 500, 600, 1100, 1600, 2000, 2400, 3400, 5110, 5200	*RAC1*	*Both*	*$81.47*	*$69.99*
ACG 400, 700, 900, 1000, 1200, 1300, 1710, 1800, 1900, 2100, 2200, 2300, 2800, 2900, 3000, 3100, 5310	*RAC2*	*Both*	*$109.05*	*$93.54*
ACG 1720, 1730, 2500, 3200, 3300, 3500, 3800, 4210, 5230, 5339	*RAC3*	*Both*	*$138.63*	*$118.92*
ACG 800, 1740, 1750, 2700, 3600, 3700, 3900, 4000, 4100, 4220, 4310, 4410, 4510, 4610, 4710, 4720, 4810, 5340	*RAC4*	*Both*	*$225.20*	*$193.18*
AGC 1400, 1500, 1750, 1770, 2600, 4320, 4520, 4620, 4820	*RAC5*	*Both*	*$306.91*	*$263.28*
ACG 4330, 4420, 4830, 4910, 4920, 5010, 5020, 5040	*RAC6*	*Both*	*$506.37*	*$434.37*
ACG 4430, 4730, 4930, 5030, 5050	*RAC7*	*Both*	*$651.17*	*$558.59*
ACG 4940, 5060	*RAC8*	*Both*	*$1,010.44*	*$866.77*
ACG 5070	*RAC9*	*Both*	*$1,266.45*	*$1,086.38*
SOBRA Mothers			*$621.39*	*$487.21*
Persons with HIV	*All*	*Both*	*$705.24*	*$705.24*

(b) Rate Table for Disabled Individuals. Effective July 1, 2005 — December 31, 2005

Demographic Cells	*Age*	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
	Under Age 1	*Both*	*$1,837.50*	*$1,837.50*
	1 — 5	*Male*	*$633.78*	*$633.78*
		Female	*$679.03*	*$679.03*
	6 — 14	*Male*	*$136.78*	*$136.78*
		Female	*$250.59*	*$250.59*
	15 — 20	*Male*	*$321.55*	*$321.55*
		Female	*$373.39*	*$373.39*
	21 — 44	*Male*	*$1,146.96*	*$899.30*
		Female	*$1,066.56*	*$836.26*
	45 — 64	*Male*	*$1,491.91*	*$1,169.77*
		Female	*$1,424.42*	*$1,116.85*

	Age	*Gender*	*PMPM Baltimore City*	*PMPM Rest of State*
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*	*$219.59*	*$188.37*
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*	*$331.86*	*$284.67*
ACG 600, 1760, 3600, 3700, 4100, 4320, 4410, 4710, 4810, 4820	*RAC12*	*Both*	*$588.02*	*$504.41*
ACG 3800, 4210, 4220, 4330, 4420, 4720, 4910, 5320	*RAC13*	*Both*	*$709.52*	*$608.64*
ACG 800, 4430, 4510, 4610, 5040, 5340	*RAC14*	*Both*	*$906.80*	*$777.87*
ACG 1770, 4520, 4620, 4830, 4920, 5050	*RAC15*	*Both*	*$1,050.13*	*$900.82*
ACG 4730, 4930, 5010	*RAC16*	*Both*	*$1,321.86*	*$1,133.91*
ACG 4940, 5020, 5060	*RAC17*	*Both*	*$1,799.07*	*$1,543.28*
ACG 5030, 5070	*RAC18*	*Both*	*$2,383.25*	*$2,044.39*
Persons with AIDS	*All*	*Both*	*$3,201.62*	*$2,689.33*
Persons with HIV	*All*	*Both*	*$1,849.19*	*$1,849.19*

(c) Rate Table for Supplemental Payment for Delivery/Newborn Effective July 1, 2005 — December 31, 2005

	Age/RAC	*Gender*	*Baltimore City*	*Rest of State*
Supplemental Payment Cells				
Delivery/Newborn — live birth weight over 1,500 grams	*All*	*Both*	*$11,279.39*	*$8,671.18*
Delivery/Newborn — live birth weight 1,500 grams or less	*All*	*Both*	*$80,312.76*	*$56,751.83*

(d) — (g) (text unchanged)

(5) [The] *Consistent with the terms set forth in Regulation .19-5 of this chapter, the* Department may, in consultation with the Commissioner, adjust the capitation payment of an MCO if it determines that the MCO's loss ratio, not including any rebate received by the MCO[:

(a) For an MCO that is not approved as an HMO:

(i) Is less than 80 percent during calendar year 1997, and

(ii) Is less than 85 percent for each calendar year thereafter;

(b) For an MCO that is a certified HMO:

(i) For services provided to recipients, is less than 80 percent during calendar year 1997, and

(ii) For services provided to recipients, is less than 85 percent for each calendar year thereafter.] *is less than 85 percent.*

C. — D. (text unchanged)

.19-5 MCO Loss Ratio.

A. The Department shall determine an MCO's annual loss ratio as provided in this regulation.

B. The Department shall:

(1) Review an MCO's annual HFMR submitted pursuant to Regulation .15E of this chapter; and

(2) By December 30 of the calendar year following the service year, submit the HFMR data received from the MCOs to an accounting contractor retained by the Department to independently review the reports.

C. The Department's accounting contractor shall:

(1) Review the expenses and revenues reported by each MCO in its HFMR; and

(2) By May 1 of the second calendar year after the service year, report to the Department the results of its review.

D. After reviewing the accounting contractor's report, the Department may adjust HFMR-reported expenses and revenues in accordance with the opinion of the accounting contractor.

E. Components of Medical Loss.

(1) An MCO's total medical expense consists of the costs incurred by the MCO in providing health care services to its enrollees during the service year.

(2) An MCO's total medical management expense includes the MCO's costs of performing the following activities during the service year:

(a) Outreach activities that:

(i) Educate enrollees as to how they can access covered benefits and services efficiently; and

(ii) Promote enrollee health;

(b) Utilization management activities that manage medically necessary covered benefits and services, including:

(i) Nurse advice lines;

(ii) Prospective and concurrent utilization review;

(iii) Case management services provided to enrollees with high-cost medical conditions to improve continuity and quality of care in a cost-effective manner;

(iv) Disease management services that, through a process of coordinated health care interventions that emphasize prevention and management, intensively manage the care of enrollees with specific conditions; and

(v) Quality management activities designed to achieve optimal health outcomes in a cost-effective manner, including but not limited to those required by Regulations .03, .04, and .27 of this chapter.

F. Annual Loss Ratio Calculation.

(1) In calculating an MCO's annual loss ratio, the Department shall use data:

(a) Submitted by the MCO pursuant to Regulation .15E of this chapter and adjusted, as appropriate, according to §D of this regulation; and

(b) That represent revenues earned and expenses incurred solely from the MCO's MMMCP-related activities.

(2) To calculate an MCO's annual loss ratio, the Department shall:

(a) Add the following expenses incurred by the MCO during the service year, as specified in §E of this regulation:

(i) Net medical expenses; and

(ii) Medical management expenses; and

(b) Divide the result of the computation specified in §F(2)(a) of this regulation by the MCO's net revenues for the service year.

G. Insufficient Loss Ratio.

(1) If an MCO's annual loss ratio for the service year, determined according to §F of this regulation, is less than 85 percent, the Secretary shall consider the MCO's past performance pursuant to §G(2) of this regulation.

(2) The Secretary, in consultation with the Commissioner may adjust an MCO's capitation payments according to §H of this regulation, if the MCO is determined to have:

(a) A loss ratio for the service year of less than 85 percent; and

(b) An average annual loss ratio for the 3-year period ending with the service year of less than 85 percent.

(3) The Secretary, in consultation with the Commissioner, may waive a capitation adjustment based on loss ratio if, in the calendar year corresponding to the year for which an adjustment is considered:

(a) The loss ratio of the MCO is less than 85 percent but equal to or more than 80 percent; and

(b) All of the MCO's scores on the Department's core performance measures are in the top two levels of performance.

H. Adjustment Amount.

(1) The Secretary, in consultation with the Commissioner, may adjust an MCO's capitation payments in the amounts specified in §H of this regulation:

(a) For the first year in which an adjustment is made pursuant to this capitation, the adjustment may not exceed 50 percent of the difference between the capitation amount:

(i) Actually paid by the Department to the MCO during the service year; and

(ii) That, if paid by the Department during the service year instead of the actual payment amount, would have resulted in the MCO having a loss ratio of 85 percent for the service year; and

(b) For the second year in which an adjustment is made pursuant to this regulation, the adjustment may not exceed 75 percent of the difference between the capitation amount:

(i) Actually paid by the Department to the MCO during the service year; and

(ii) That, if paid by the Department during the service year instead of the actual payment amount, would have resulted in the MCO having a loss ratio of 85 percent for the service year; and

(c) For the third year in which an adjustment is made pursuant to this regulation and thereafter, the adjustment may not exceed 100 percent of the difference between the capitation amount:

(i) Actually paid by the Department to the MCO during the service year; and

(ii) That, if paid by the Department during the service year instead of the actual payment amount, would have resulted in the MCO having a loss ratio of 85 percent for the service year.

(2) Withholding Limitation.

(a) Unless the MCO and the Department agree otherwise, the Department may not withhold more than 1/12 of the total adjustment amount authorized by §H(1) of this regulation from a single monthly capitation payment.

(b) The limitation set forth in §H(2)(a) of this regulation:

(i) Applies only to amounts withheld pursuant to this regulation; and

(ii) Does not affect the Department's authority to withhold or reduce an MCO's capitation payments for any of the reasons set forth in COMAR 10.09.73.01.

I. Notice and Appeal.

(1) At least 30 days before it implements a capitation payment adjustment authorized by this regulation, the Department shall provide written notice to the affected MCO.

(2) The Department shall specify in the notice required by §I(1) of this regulation:

(a) The amount of the adjustment;

(b) The reason for the adjustment; and

(c) The date of the monthly capitation payment from which the Department intends to withhold the first component of the total adjustment amount.

(3) Within 30 days of its receipt of the notice required by §I(2) of this regulation, an MCO may appeal the adjustment as a sanction pursuant to COMAR 10.09.72.06.

(4) An MCO's appeal under §I(3) of this regulation does not stay the Department's authority, during the pendency of the appeal, to withhold from capitation payments adjustment amounts as provided in §H of this regulation.

10.09.67 Maryland Medicaid Managed Care Program: Benefits

Authority: Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland

.01 Required Benefits Package — In General.

A. — C. (text unchanged)

D. Cost Sharing and Prohibitions.

(1) Except for the following, an MCO may not charge its enrollees any copayments, premiums, or cost sharing:

(a) Up to a **[$2]** *$3* copayment for brand-name drugs;

(b) Up to *a* $1 copayment for generic drugs;

(c) — (d) (text unchanged)

(2) (text unchanged)

E. — F. (text unchanged)

S. ANTHONY McCANN
Secretary of Health and Mental Hygiene

Subtitle 27 BOARD OF NURSING

10.27.06 Practice of Nurse Anesthetist

Authority: Health Occupations Article, §8-205, Annotated Code of Maryland

Notice of Proposed Action

[05-184-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation .02 under **COMAR 10.27.06 Practice of Nurse Anesthetist**. This action was considered by the