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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organization Transmittal No. 75
July 20, 2009

TO: Managed Care Organizations

FROM: Susan J. 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 and PAC Regulations

WRITTEN COMMENTS TO:
Michelle Phinney
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Fax (410) 767-6483 or call
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COMMENT PERIOD EXPIRES: August 17, 2009

The Maryland Medical Assistance Program is promulgating proposed amendments to: Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions; Regulation .09 under COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application; Regulations .02, .03, .11, .17, .19-3, and .20 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; Regulations .01, .21 and 28 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits; Regulations. 05, .14, and 17 under COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management; Regulation .10 and repeal Regulation .11 under COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System; Regulation .02—.05 under COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures; Regulation .05 under COMAR 10.09.72 Maryland Medicaid Managed Care Program: Department Dispute Resolution Procedures; Regulation .04 under COMAR

10.09.75 Maryland Medicaid Managed Care Program: Corrective Managed Care; and Regulation .06 and .08 under COMAR 10.09.76 Primary Adult Care Program.

These amendments will:

(1) Remove obsolete and update incorrect definitions under COMAR 10.09.62.01;
(2) Correct the name of the Healthcare Effectiveness Data Information Set (HEDIS);
(3) Update incorrect references under COMAR 10.09.65.02C, 10.09.65.17B, and 10.09.72.05C;
(4) Replace audit with Systems Performance Review and remove outdated performance measures from the Quality and Assessment regulations;
(5) Remove reference to targets under HEDIS as targets are not set for HEDIS;
(6) Correct the acronym for the Substance Abuse and Mental Health Services Administration (SAMHSA);
(7) Update the dates and amounts of the Statewide and Rural Supplemental Payments and the number of counties in which the MCOs must operate in order to receive the Statewide Supplemental payments;
(8) Allow enrollees to self-refer for certain substance abuse services;
(9) Remove emergency room copayments;
(10) Update the ICD-9 codes under REM and SMHS;
(11) Add rates and descriptions of levels of care under REM;
(12) Repeal COMAR 10.09.70.11 as it is no longer applicable;
(13) Update language regarding non-English requirement for certain documents under enrollee appeals to coincide with other references to these documents in regulations;
(14) Require MCOs to acknowledge receipt of all appeals within 5 business days of receipt;
(15) Allow providers 90 days from date of denial to file an appeal;
(16) Require MCOs to resolve provider appeals within 90 days of receipt;
(17) Require MCOs to make payment on overturned appeals within 30 days;
(18) Remove requirement that enrollees be copied on post-service denials of payment;
(19) Add reference to MCO appeal process under Corrective Managed Care as the regulations currently reference only the Department's appeal process;
(20) Update incorrect references under the PAC subcontractual relationships regulations; and
(21) Update preauthorization timelines under PAC to coincide with HealthChoice timelines.

Questions regarding these amendments should be directed to the Division of HealthChoice Management and Quality Assurance at (410) 767-1482.

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[09-214-P]

The Secretary of Health and Mental Hygiene proposes to amend:

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

(2) Regulation **.09** under **COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application**;

(3) Regulations **.02**, **.03**, **.11**, **.17**, **.19-3**, and **.20** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations**;

(4) Regulations **.01**, **.21**, and **.28** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**;

(5) Regulations **.05**, **.14**, and **.17** under **COMAR 10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management**;

(6) Regulation **.10**, and repeal Regulation **.11** under **COMAR 10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System**;

(7) Regulations **.02—.05** under **COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures**;

(8) Regulation **.05** under **COMAR 10.09.72 Maryland Medicaid Managed Care Program: Department Dispute Resolution Procedures**;

(9) Regulation **.04** under **COMAR 10.09.75 Maryland Medicaid Managed Care Program—Corrective Managed Care**; and

(10) Regulations **.06** and **.08** under **COMAR 10.09.76 Primary Adult Care Program**.

Statement of Purpose

The purpose of this action is to:

(1) Remove obsolete and update incorrect definitions under COMAR 10.09.62.01;

(2) Correct the name of the Healthcare Effectiveness Data Information Set (HEDIS);

(3) Update incorrect references under COMAR 10.09.65.02C, 10.09.65.17B, and 10.09.72.05C;

(4) Replace audit with Systems Performance Review and remove outdated performance measures from the Quality and Assessment regulations;

(5) Remove reference to targets under HEDIS as targets are not set for HEDIS;

(6) Correct the acronym for the Substance Abuse and Mental Health Services Administration (SAMHSA);

(7) Update the dates and amounts of the Statewide and Rural Supplemental Payments and the number of counties in which the MCOs must operate in order to receive the Statewide Supplemental payments;

(8) Allow enrollees to self-refer for certain substance abuse services;

(9) Remove emergency room copayments;

(10) Update the ICD-9 codes under REM and SMHS;

(11) Add rates and descriptions of levels of care under REM;

(12) Repeal COMAR 10.09.70.11 as it is no longer applicable;

(13) Update language regarding non-English requirement for certain documents under enrollee appeals to coincide with other references to these documents in regulations;

(14) Require MCOs to acknowledge receipt of all appeals within 5 business days of receipt;

(15) Allow providers 90 days from date of denial to file an appeal;

(16) Require MCOs to resolve provider appeals within 90 days of receipt;

(17) Require MCOs to make payment on overturned appeals within 30 days;

(18) Remove requirement that enrollees be copied on post-service denials of payment;

(19) Add reference to MCO appeal process under Corrective Managed Care as the regulations currently reference only the Department's appeal process;

(20) Update incorrect references under the PAC subcontractual relationships regulations; and

(21) Update preauthorization timelines under PAC to coincide with HealthChoice timelines.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. If there is any economic impact due to the change in the Specialty Mental Health diagnosis codes, it cannot be determined until the MCOs submit their HealthChoice Financial Monitoring Reports (HFMR) for CY 2009 during the first quarter of 2010.

II. Types of Economic Impact.	Revenue (R+/R–) Expenditure (E+/E–)	Magnitude
A. On issuing agency:	(R+)	Indeterminable
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (–)	Magnitude
D. On regulated industries or trade groups:	(-)	Indeterminable
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. and D. The economic impact, if any, due to the change in the Specialty Mental Health diagnosis codes cannot be determined until the MCOs submit their HealthChoice Financial Monitoring Reports (HFMR) during CY 2009 during the first quarter of 2010.

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 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499, or email to regs@dhmh.state.md.us, or fax to 410-333-7687. Comments will be accepted through August 17, 2009. A public hearing has not been scheduled.

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)—(58-1) (text unchanged)

(59) [“Halfway house” means a transitional residential substance abuse treatment facility, certified by the Licensing and Certification Administration and the Alcohol and Drug Abuse Administration of the Department, that provides substance abuse rehabilitative treatment services, focused toward clients' employment and self-sufficiency, to clients who have received prior valuation and treatment in a primary or intermediate care program.] *Repealed.*

(60) (text unchanged)

(61) [“HCACC” means the Health Care Access and Cost Commission.] *Repealed.*

(62) (text unchanged)

(63) “HEDIS” means the [Health Plan Employer] *Healthcare Effectiveness* Data Information Set, a set of indicators of managed care plan performance developed by the National Committee for Quality Assurance.

(64)—(90) (text unchanged)

(91) “Intermediate care facility-alcoholic (ICF-A)” means an institution that:

(a) (text unchanged)

(b) Is certified as required under COMAR 10.47.01 by the Alcohol and Drug Abuse Administration and the [Licensing and Certification Administration] *Office of Health Care Quality*, or other applicable standards established by the jurisdiction in which the service is provided; and

(c) (text unchanged)

(92)—(146) (text unchanged)

(147) ["Primary medical provider (PMP)" means a provider of managed health care services to recipients under the Maryland Access to Care Program, a Medicaid §1915(b) waiver program implemented in 1991, and a predecessor to the Maryland Medicaid Managed Care Program.] *Repealed.*

(148)—(176) (text unchanged)

(177) "Serious and persistent mental disorder" means, in the context of COMAR 10.09.70, a disorder that is:

(a) [Manifest] *Manifested* in an individual 18 years old or older;

(b)—(c) (text unchanged)

(178) "Serious emotional disturbance" means, in the context of COMAR 10.09.70, a condition that is:

(a) [Manifest] *Manifested* in an individual younger than 18 years old, or, if the individual is eligible for EPSDT services, younger than 21 years old;

(b)—(c) (text unchanged)

(179)—(202) (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

.09 Quality Assurance System—General.

Unless an applicant satisfies the requirements of Regulation .08 of this chapter, it shall include in its application the following information or descriptions:

A.—F. (text unchanged)

G. The name[,] and a description[,] of the published standards or guidelines for maintenance of medical records the applicant will follow;

H.—P. (text unchanged)

10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations

Authority: Insurance Article, §§15-112, 15-605, and 15-1008; Health-General Article, §§2-104, 15-102.3, and 15-103; Annotated Code of Maryland

.02 Conditions for Participation.

A.—BB. (text unchanged)

CC. For complaints of provider fraud and abuse that warrant a preliminary investigation, the MCO's report required in [§S] *§T* of this regulation shall include:

(1)—(8) (text unchanged)

.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 enrollee health care. These activities include, but are not limited to:

(1) An annual [quality of care audit] *Systems Performance Review (SPR)* performed by an external quality review organization hired by the Department to assess an MCO's structure and operations in order to determine its ability to provide health care to its enrollees as follows:

(a) The [audit] *SPR* standards and criteria shall include at a minimum all applicable standards in the Health Care Quality Improvement System (HCQIS);

(b) The [audit] *SPR* shall include, but not be limited to:

(i)—(vii) (text unchanged)

(c) The results of the [audit] *SPR* shall be reported in draft to the MCOs for comment;

(d) (text unchanged)

(e) The Department shall issue a final report of the [audit] *SPR* results;

(2) The annual collection, validation, and evaluation of the latest approved version of the [Health Employer] *Healthcare*

Effectiveness Data and Information Set (HEDIS) in order to assess the access to and quality of services provided as follows:

(a)—(b) (text unchanged)

(c) At least 90 days before the audit process, the Department shall identify all measures to be collected [as well as the target for each];

(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 measures 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; and

(x) Claims adjudication] *in §B(3)(g) of this regulation*;

(b)—(k) (text unchanged)

(4)—(6) (text unchanged)

C. (text unchanged)

.11 Special Needs Populations—Individuals in Need of Substance Abuse Treatment.

A.—D. (text unchanged)

E. An MCO shall use a formal substance abuse screening instrument that is:

(1) (text unchanged)

(2) Recommended by the Substance Abuse and Mental Health Services Administration [(SAMSA)] *(SAMHSA)* of the U.S. Department of Health and Human Services, and appropriate for the age of the patient.

F.—I. (text unchanged)

.17 Subcontractual Relationships.

A. (text unchanged)

B. Subcontractual Relations Reporting Requirements.

(1)—(3) (text unchanged)

(4) Termination.

(a) When an MCO and provider terminate their contract the MCO shall provide the Department with a written notice regarding the termination of care or services if more than 50 enrollees are affected, as specified in [§B(3)(b) or (c)] *§B(4)(b) or (c)* of this regulation, within the following time frames:

(i)—(ii) (text unchanged)

(b)—(c) (text unchanged)

C.—E. (text unchanged)

.19-3 MCO Statewide and Rural Supplemental Payments.

A. Statewide Supplemental Payment.

(1) On the payment dates specified in §A(2) 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 all local access areas within [at least 20 of the 24] *the following number of* State jurisdictions:

(a) Effective January 1, 2009, 21 out of 24;

(b) Effective July 1, 2009, 22 out of 24; and

(c) Effective January 1, 2010, 24 out of 24.

(2) MCOs are eligible to receive a Statewide supplemental payment or payments if the following conditions are met:

(a) For [June 2008] *June's* payment:

(i) (text unchanged)

(ii) The qualifications set forth in §A(1) of this regulation were met from January 1 through June 30[, 2008] *of the current*

year; and

(b) For [December 2008] *December's* payments:

(i) (text unchanged)

(ii) The qualifications set forth in §A(1) of this regulation were met from July 1 through December 31[, 2008] *of the current year*.

(3) Amount of Statewide Supplemental Payments.

(a) The June [2008] *2009* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in May [2008] *2009* prospectively for that MCO's June [2008] *2009* enrollment, multiplied by [$3.94] *$2.45* per enrollee.

(b) The December [2008] *2009* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in November [2008] *2009* prospectively for that MCO's December [2008] *2009* enrollment, multiplied by [$3.94] *$2.45* per enrollee.

B. Supplemental Payment for Rural Enrollment.

(1)—(2) (text unchanged)

(3) Amount of Rural Enrollment [Supplement] *Supplemental* Payment.

(a) For the June [2008] *2009* payments to MCOs meeting the requirements specified in §A of this regulation from January 1 through June 30, [2008] *2009*, the Department shall pay an amount equal to the total number of that MCO's enrollees in counties specified in §B(4) of this regulation and paid for in May [2008] *2009* prospectively for that MCO's June [2008] *2009* enrollment, multiplied by [$17.46] *$20.95* per enrollee.

(b) For the December [2008] *2009* payments to MCOs meeting the requirements specified in §A of this regulation from July 1 through December 31, [2008] *2009*, the Department shall pay each qualifying MCO an amount equal to the total number of that MCO's enrollees in counties specified in §B(4) of this regulation and paid for in November [2008] *2009* prospectively for that MCO's December [2008] *2009* enrollment, multiplied by [$17.46] *$20.95* per enrollee.

(4) (text unchanged)

C. (text unchanged)

.20 MCO Payment for Self-Referred, Emergency, and Physician Services.

A. MCO Payment for Self-Referred Services.

(1)—(9) (text unchanged)

(10) An MCO shall reimburse out-of-plan providers, excluding local health departments, at the Medicaid fee-for-service rate for:

(a) A comprehensive substance abuse assessment (CSAA), as described in COMAR 10.09.65.11, if the following conditions are met:

(i) The recipient is not in substance abuse treatment;

(ii) The recipient has not received a self-referred CSAA that calendar year; and

(iii) The assessment provider is an Alcohol and Drug Abuse Administration certified substance abuse provider; and

(b) Substance abuse services as described in COMAR 10.09.67.28I.

(11) Local health departments are paid the following rates for self-referred substance abuse services:

(a) $41.56 for:

(i) Group counseling; and

(ii) Intensive outpatient treatment.

(b) $121.89 for:

(i) CSAAs;

(ii) Individual counseling; and

(iii) Methadone treatment.

B.—C. (text unchanged)

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) (text unchanged)

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

[(c) Up to a $6 copayment for non-emergency use of an emergency room; or]

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

(2) (text unchanged)

E.—G. (text unchanged)

.21 Benefits—Pregnancy-Related Services.

A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including:

(1) (text unchanged)

(2) Prenatal risk assessment and development[,] *of* an individualized plan of care that specifies the actions required to address each identified need and is appropriately modified during the course of care;

(3) (text unchanged)

B.—D. (text unchanged)

.28 Benefits—Self-Referral Services.

An MCO shall be financially responsible for reimbursing, in accordance with COMAR 10.09.65.20, an out-of-plan provider chosen by the enrollee for the following services:

A.—G. (text unchanged)

H. A comprehensive substance abuse assessment (CSAA), as described in COMAR 10.09.65.11, if the following conditions are met:

(1)—(2) (text unchanged)

(3) The assessment provider is an Alcohol and Drug Abuse Administration certified substance abuse provider; [and]

I. Substance abuse services that:

(1) Are provided by an ADAA certified provider if the MCO determines that the enrollee has met the American Society of Addictions Medicine (ASAM) level of care for the services being provided;

(2) Meet all other conditions as determined by the Department; and

(3) Include but are not limited to:

(a) For all recipients:

(i) Inpatient detoxification in an acute hospital;

(ii) A minimum of 5 days of hospital or community-based outpatient detoxification;

(iii) A minimum of 2 days of partial hospitalization;

(iv) A minimum of 13 weeks initially of opioid maintenance with an additional 13 weeks following submission of a treatment plan by the treating provider; and

(v) A minimum of 30 sessions of individual, family, or group counseling within a 6-month period;

(b) For recipients who are younger than 21 years old:

(i) The benefits described in §I(3)(a) of this regulation;

(ii) A minimum of 30 days of intensive outpatient treatment; and

(iii) Residential services provided in an Intermediate Care Facility—Addictions (ICF-A); and

(c) For recipients who are 21 years old or older, and pregnant or postpartum, the benefits described in §I(3)(a) and (b)(ii) of this regulation; and

[I.] *J.* (text unchanged)

10.09.69 Maryland Medicaid Managed Care Program: Rare and Expensive Case Management

Authority: Health-General Article, §15-102.1(b)(1) and 15-103(b)4)(i), Annotated Code of Maryland

.05 Benefits.

A REM participant is eligible for the following:

A.—B. (text unchanged)

C. [Case] *A case* management [services] *assessment* performed by a REM case manager who shall:

(1) (text unchanged)

(2) Consult with the participant's current service providers; *and*

(3) Evaluate the relevant information and complete a needs analysis including medical, psychosocial, environmental, and functional assessments; *and*

D. Case management services performed by a REM case manager who shall:

[(4)] *(1)*—[(10)] *(7)* (text unchanged)

.14 Payment Procedures—Request for Payment.

A.—D. (text unchanged)

E. Effective July 1, 2009, the Department shall pay $406 for case management assessment, as described in Regulation .05C of this chapter.

F. Effective July 1, 2009, the Department shall make payments monthly for case management services at one of the rates specified below:

(1) Level of Care 1: $302;

(2) Level of Care 2: $180; or

(3) Level of Care 3: $95.

G. The rates found in §F of this regulation are the monthly rates paid by the Department for an individual receiving case management as follows:

(1) Level of Care 1 is intensive level of case management, assessment, and coordination of services for an individual who:

(a) Is acutely ill;

(b) Has an unstable clinical condition;

(c) Has an exacerbated chronic illness; or

(d) Has a newly diagnosed condition;

(2) Level of Care 2 is case management to an individual who has a history of exacerbations of medical issues requiring services on an ongoing basis to attain stable service or treatment plans; and

(3) Level of Care 3 is case management that is required on an ongoing basis to monitor a recipient's stability and treatment plans.

.17 Table of Rare and Expensive Disease List.

ICD-9	Disease	Age Group
042—585.9 (text unchanged)		
585.6, [V45.1] *V45.11*	Chronic renal failure with dialysis	21—64
741.00—V46.1 (text unchanged)		

10.09.70 Maryland Medicaid Managed Care Program: Specialty Mental Health System

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

.10 Mental Health Diagnoses and Service Array.

A. The SMHS system shall treat waiver-eligible individuals with one of the following mental illnesses diagnosed according to the International Classification of Diseases, 9th Revision (ICD-9):

(1)—(4) (text unchanged)

(5) [302.8-302.9] *302.81—302.9*;

(6)—(8) (text unchanged)

(9) 308.0—[314.90] *308.9*;

(10) 309.0—309.9;

(11) 311;

(12) 312.0—312.9;

(13) 313.0—313.82;

(14) 313.89—314.9;

[(10)] *(15)*—[(11)] *(16)* (text unchanged)

[(12) 333.7;]

[(13)] *(17)*—[(14)] *(18)* (text unchanged)

[(15)] *(19)* 333.92; *or*

[(16)] *(20)* 333.99[; or

(17) 787.6].

B. (text unchanged)

C. Service Array. Mental health services include:

(1) (text unchanged)

(2) As State resources permit, the following services, which are not Medicaid-reimbursable:

(a) Residential programs, including:

(i) (text unchanged)

(ii) Therapeutic group homes, under COMAR 10.21.07[,] *; and*

[(iii) Psychiatric halfway house services, and]

[(iv)] *(iii)* (text unchanged)

(b)—(g) (text unchanged)

D.—E. (text unchanged)

10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures

Authority: Health-General Article, §15-103(b)(i)(4), Annotated Code of Maryland

.02 Internal Complaint Process for Enrollees.

A. An MCO shall have written [grievance] *complaint* procedures by which an enrollee who is dissatisfied with the MCO or its network providers, or decisions made by the MCO or a provider, may seek recourse verbally or in writing within the MCO.

B. An MCO shall:

(1)—(2) (text unchanged)

(3) Prepare the document describing the MCO's internal complaint process [in]*:*

(a) In a culturally sensitive manner[, at a suitable] *;*

(b) At an appropriate reading comprehension level [,] *;* and [in]

(c) In the [enrollee's native tongue if the enrollee is a member of a substantial minority] *prevalent non-English languages, identified by the State*; and

(4) (text unchanged)

C. (text unchanged)

.03 MCO Provider Complaint Process.

A. (text unchanged)

B. An MCO shall include in its provider complaint process at least the following elements:

(1)—(6) (text unchanged)

(7) An appeal process which:

(a) (text unchanged)

(b) Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO;

(c) Allows providers 90 business days from the date of a denial to file an initial appeal;

(d) Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal;

(e) Resolves appeals, regardless of the number of appeal levels allowed by the MCO, within 90 business days of receipt of the initial appeal by the MCO;

(f) Pays claim within 30 days of the appeal decision when a claim denial is overturned;

[(b)] *(g)*—[(d)] *(i)* (text unchanged)

(8) (text unchanged)

C. (text unchanged)

.04 Actions and Decisions.

A.—C. (text unchanged)

D. An MCO shall give an enrollee written notice of any action, *except for denials of payment which do not require notice to the enrollee,* within the following time frames:

(1)—(4) (text unchanged)

E.—F. (text unchanged)

.05 Appeal Process for Enrollees.

A. An MCO's appeal process shall:

(1) (text unchanged)

(2) Include procedures for acknowledging receipt of appeals within 5 business days;

[(2)] *(3)*—[(7)] *(8)* (text unchanged)

B.—C. (text unchanged)

10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures

Authority: Health-General Article, §15-103(b)(9)(i)4, Annotated Code of Maryland

.05 Enrollee Appeal.

A.—B. (text unchanged)

C. Hearings.

(1) The waiver-eligible individual may appeal a decision listed in §B of this regulation to the Office of Administrative Hearings as specified in COMAR [10.09.36.09] *10.01.04*.

(2)—(8) (text unchanged)

D.—E. (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

.04 Enrollment in Corrective Managed Care.

A.—C. (text unchanged)

D. Enrollee Appeal.

(1) An individual placed into corrective managed care may appeal the decision as specified in COMAR *10.09.71.05 and* 10.09.72.05.

(2) (text unchanged)

10.09.76 Primary Adult Care Program

Authority: Health-General Article, §15-101[,] *and* 15-103, [and 15-140,] Annotated Code of Maryland

.06 Provider Networks.

A. (text unchanged)

B. Subcontractual Relationships.

(1) Subcontracting Permitted.

(a) (text unchanged)

(b) Subcontractual relationships shall meet the requirements specified in COMAR [10.09.65.17A(2)—(4)(i)] *10.09.65.17A (2)—(4), (5)(a)—(i) and (k)* and B.

(2)—(4) (text unchanged)

.08 Access Standards.

A. (text unchanged)

B. Clinical Access and Appointment Times.

(1)—(2) (text unchanged)

(3) Response Time. An MCO shall respond in a timely manner to its PAC enrollees' needs and requests, as follows:

(a)—(b) (text unchanged)

(c) For services to enrollees that require preauthorization by the MCO, the MCO shall provide the preauthorization in a timely manner so as not to adversely affect the health of the enrollee, *and within 2 days of receipt of necessary clinical information* but not later than [72 hours] *7 days* after the initial request; and

(d) (text unchanged)

(4) (text unchanged)

C.—D. (text unchanged)

JOHN M. COLMERS
Secretary of Health and Mental Hygiene