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. 71

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: Amendments to HealthChoice and PAC Regulations

Effective November 1, 2008, the AELR Committee has granted emergency status to the proposed regulations as printed in the November 7, 2008 issue of the Maryland Register. The Notice of Emergency Action was printed in the November 21, 2008 issue. Copies of both are attached.

The regulations affected are: Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions; Regulation .05 under COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment; Regulation .11 under COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application; Regulations .02, .03, .05, .11, .15, .19, .20, .23, and .24 under COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations; Regulations .01 and .04 under COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access; Regulation .03 under COMAR 10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers; Regulations .01 and .02 under COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures; Regulation .04 under COMAR 10.09.72 Maryland Medicaid Managed Care Program: Department Dispute Resolution Procedures and Regulations .03 and .16 under COMAR 10.09.76 Primary Adult Care Program.

The Proposal removes the definition of historic provider as it is no longer used in regulations, updates time frame for enrollees to receive their annual right to change packets to comply with requirements of the BBA, corrects the name of the CMS1500 and UB94 forms, updates incorrect references under 10.09.65.02 S and 10.09.65.11 that were the result of previous changes in regulation language, updates referral requirements for children with special

healthcare needs, removes 2006 value based purchasing language and adds incentives for 2009, updates the year from 2007 to 2008 for the statewide and rural supplemental payments, requires MCOs to pay the Medicaid rate to non-participating physicians providing services in a hospital, updates marketing regulations to coincide with Department's current policy, removes the 70% dental utilization requirement for 2004, updates language under 10.09.66 which pertains to written materials to coincide with other regulations that reference written materials, update language under 10.09.66.04 to clarify that it refers to an enrollee's appeal rights, updates language that refers to enrollees as consumers, updates language to clarify references to appeals and grievances vs. complaints for consistency with current definitions, allows enrollees 90 instead of 30 days to file an appeal, updates language to clarify the Department's complaint resolution process, and corrects language under 10.09.75.02 that refers to criteria as procedures.

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

Attachments

Maryland Register

Issue Date: November 21, 2008

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Title 10
DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Subtitle 09 MEDICAL CARE PROGRAMS
Notice of Emergency Action

[08-326-E]

The Joint Committee on Administrative, Executive, and Legislative Review has granted emergency status to amendments to:

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

(2) Regulation **.05** under **COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment**;

(3) Regulation **.11** under **COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application**;

(4) Regulations **.02**, **.03**, **.05**, **.11**, **.15**, **.19-3**, **.20**, **.23**, and **.24** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations**;

(5) Regulations **.01** and **.04** under **COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access**;

(6) Regulation **.07** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**;

(7) Regulation **.03** under **COMAR 10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers**;

(8) Regulations **.01—.03** and **.05** under **COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures**;

(9) Regulation **.04** under **COMAR 10.09.72 Maryland Medicaid Managed Care Program: Department Dispute Resolution Procedures**;

(10) Regulation **.02** under **COMAR10.09.75 Maryland Medicaid Managed Care Program: Corrective Managed Care**; and

(11) Regulations **.03** and **.16** under **COMAR 10.09.76 Primary Adult Care Program**.

Emergency status began: November 1, 2008.

Emergency status expires: April 29, 2009.

Editor's Note: The text of this document will not be printed here because it appeared as a Notice of Proposed Action in 35:23 Md. R. 2021—2026 (November 7, 2008), referenced as [08-326-P].

JOHN M. COLMERS
Secretary of Health and Mental Hygiene

Maryland Register

Issue Date: November 7, 2008

Volume 35 • Issue 23 • Pages 1995—2044

Subtitle 09 MEDICAL CARE PROGRAMS

Notice of Proposed Action

[08-326-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 **.05** under **COMAR 10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment**;

(3) Regulation **.11** under **COMAR 10.09.64 Maryland Medicaid Managed Care Program: MCO Application**;

(4) Regulations **.02**, **.03**, **.05**, **.11**, **.15**, **.19-3**, **.20**, **.23**, and **.24** under **COMAR 10.09.65 Maryland Medicaid Managed Care Program: Managed Care Organizations**;

(5) Regulations **.01** and **.04** under **COMAR 10.09.66 Maryland Medicaid Managed Care Program: Access**;

(6) Regulation **.07** under **COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits**;

(7) Regulation **.03** under **COMAR 10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers**;

(8) Regulations **.01—.03** and **.05** under **COMAR 10.09.71 Maryland Medicaid Managed Care Program: MCO Dispute Resolution Procedures**;

(9) Regulation **.04** under **COMAR 10.09.72 Maryland Medicaid Managed Care Program: Departmental Dispute Resolution Procedures**;

(10) Regulation **.02** under **COMAR 10.09.75 Maryland Medicaid Managed Care Program: Corrective Managed Care**; and

(11) Regulations **.03** and **.16** under **COMAR 10.09.76 Primary Adult Care Program**.

Statement of Purpose

The purpose of this action is to:

(1) Remove the definition of "historic provider" since it is no longer used in the regulations;

(2) Update time frame for enrollees to receive their annual right to change packets to comply with the requirements of the Balanced Budget Act of 1997;

(3) Correct the names of certain forms;

(4) Update incorrect references under COMAR 10.09.65;

(5) Update referral requirements for children with special health care needs;

(6) Remove 2006 value based purchasing language and add incentives for 2009;

(7) Update the year from 2007 to 2008 for the Statewide and rural supplemental payments;

(8) Require MCOs to pay the Medicaid rate to non-participating physicians providing services in a hospital;

(9) Update marketing regulations to coincide with the Department's current policy;

(10) Remove the 70 percent dental utilization requirement for 2004;

(11) Update language under 10.09.66 which pertains to written materials to coincide with other regulations that reference written materials;

(12) Update language under 10.09.66.04 to clarify that it refers to an enrollee's appeal rights;

(13) Require MCOs to pay for medically necessary ancillary services provided on inpatient hospital days;

(14) Update language that refers to enrollees as consumers;

(15) Update language to clarify references to appeals and grievances versus complaints for consistency with current definitions;

(16) Allow enrollees 90 instead of 30 days to file an appeal;

(17) Update language to clarify the Department's complaint resolution process; and

(18) Correct language under 10.09.75.02 that refers to criteria as procedures.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

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 December 8, 2008. 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)—(69) (text unchanged)

(70) **[**"Historic provider" means a health care provider, as defined in Health-General Article, §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.] *Repealed.*

(71)—(202) (text unchanged)

10.09.63 Maryland Medicaid Managed Care Program: Eligibility and Enrollment

Authority: Health-General Article, §15-103(b)(23),
Annotated Code of Maryland

.05 Reassignment.

A. (text unchanged)

B. [Before] *Sixty days before* an enrollee's anniversary date of enrollment, the Department shall notify the enrollee [that the enrollee has 21 days to notify the Department of a decision to enroll in a new MCO] *of the annual right to change the enrollee's MCO.*

C.—H. (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

.11 Management Information System and Data Reporting.

An MCO applicant shall include in its application the following information or descriptions:

A.—B. (text unchanged)

C. Evidence of the applicant's ability to report, on a monthly basis, service-specific encounter data in [UB-92] *UB04* or [HCFA-1500] *CMS1500* format;

D.—E. (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.—N. (text unchanged)

O. The requirements of Regulation .17A(2) of this chapter, or **[**§N(3)**]** *§N(1)* of this regulation, may not be construed to:

(1)—(3) (text unchanged)

P.—R. (text unchanged)

S. The chief executive officer of an MCO or his or her designee shall certify, under penalty of perjury, that any books, records, files, accounts, or other documents requested under **[**§O**]** *§§Q and R* of this regulation are current, accurate, and complete to the best of that individual's knowledge.

T.—CC. (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)—(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)—(e) (text unchanged)

[(f) 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 ½ 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 ½ 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)(f)(iv) of this regulation paid to the MCOs each year cannot exceed the total amount of the penalties as described in §B(3)(f)(iii) of this regulation collected from the MCOs in that same year;**]**

[(g)**]** *(f)* (text unchanged)

(g) Effective January 1, 2009, the core performance measures are:

(i) Adolescent well care visits;

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

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

(iv) Cervical cancer screening;

(v) Diabetic eye exams;

(vi) Childhood immunizations;

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

(viii) Postpartum care;

(ix) Use of appropriate medications for people with asthma (combined); and

(x) Well child visits, 3—6 years old;

(h) Starting with the 2009 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) On any of the measures in §B(3)(g) of this regulation for which the MCO does not meet the minimum target, as determined by the Department, a penalty of of 1 percent of the total capitation amount paid to the MCO during the measurement year shall be collected;

(iv) The total amount of the penalties as described in §B(3)(h)(iii) of this regulation may not exceed ½ of 1 percent of the total capitation amount paid to the MCO during the same measurement year;

(v) On any of the measures in §B(3)(g) of this regulation for which the MCO exceeds the incentive target, as determined by the Department, the MCO shall be paid an incentive payment of up to 1/10 *of 1 percent of the total capitation paid to the MCO during that measurement year;*

(vi) The total amount of the incentive payments as described in §B(3)(h)(v) of this regulation paid to the MCOs each year may not exceed the total amount of the penalties as described in §B(3)(h)(iii) of this regulation collected from the MCOs in that same year, plus any additional funds allocated to the Department for a quality initiative; and

(vii) Any funds remaining after the payment of the incentives due under §B(3)(h)(v) shall be distributed to the MCOs receiving the four highest normalized scores for Value Based Purchasing for all ten performance measures at a rate calculated by multiplying each MCO's adjusted enrollment as of December 31 of the measurement year by a per enrollee amount;

(i) The adjusted enrollment amount in §B(3)(h)(vii) of this regulation shall be calculated by:

(i) Multiplying four times the enrollment of the MCO with the highest normalized score;

(ii) Multiplying three times the enrollment of the MCO with the second highest normalized score;

(iii) Multiplying two times the enrollment of the MCO with the third highest normalized score; and

(iv) Using the fourth MCO's actual enrollment;

(j) The per enrollee amount in §B(3)(h)(vii) of this regulation shall be calculated by dividing the sum of the calculations in §B(3)(i)(i)—(iv) of this regulation into the funds remaining as described in §B(3)(h)(vii) of this regulation;

[(h)**]** *(k)* (text unchanged)

(4)—(6) (text unchanged)

C. (text unchanged)

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

A.—H. (text unchanged)

I. The service referrals referenced in §H of this regulation shall:

(1) (text unchanged)

(2) Be made when the child is [functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.]:

(a) Identified as being at risk of a developmental delay by the developmental screen required by EPSDT;

(b) Experiencing a delay of 25 percent or more in any developmental area as measured by appropriate diagnostic instruments and procedures;

(c) Manifesting atypical development or behavior; or

(d) Diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay.

J.—K. (text unchanged)

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

A.—F. (text unchanged)

G. Based on the comprehensive substance abuse assessment and placement appraisal as specified in §E of this regulation, the MCO shall refer the enrollee to a provider that is qualified to provide the service based on the criteria set forth in [§G] *§H* of this regulation.

H.—I. (text unchanged)

.15 Data Collection and Reporting.

A. (text unchanged)

B. Encounter Data.

(1) An MCO shall submit encounter data monthly, reflecting 100 percent of provider-enrollee encounters, in [HCFA 1500] *CMS1500* and [UB92] *UB04* format or an alternative format previously approved by the Department.

(2)—(3) (text unchanged)

C.—L. (text unchanged)

.19-3 MCO Statewide and Rural Supplemental Payments.

A. Statewide Supplemental Payment.

(1) (text unchanged)

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

(a) For June [2007] *2008* payment:

(i) (text unchanged)

(ii) The qualifications set forth in §A(1) of this regulation were met from January 1 through June 30, [2007] *2008*; and

(b) For December [2007] *2008* payments:

(i) (text unchanged)

(ii) The qualifications set forth in §A(1) of this regulation were met from July 1 through December 31, [2007] *2008*.

(3) Amount of Statewide Supplemental Payments.

(a) The June [2007] *2008* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in May [2007] *2008* prospectively for that MCO's June [2007] *2008* enrollment, multiplied by $3.94 per enrollee.

(b) The December [2007] *2008* payment to a qualifying MCO will equal the total number of that MCO's enrollees paid for in November [2007] *2008* prospectively for that MCO's December [2007] *2008* enrollment, multiplied by $3.94 per enrollee.

B. Supplemental Payment for Rural Enrollment.

(1)—(2) (text unchanged)

(3) Amount of Rural Enrollment Supplement Payment.

(a) For the June [2007] *2008* payments to MCOs meeting the requirements specified in §A of this regulation from January 1 through June 30, [2007] *2008*, 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 [2007] *2008* prospectively for that MCO's June [2007] *2008* enrollment, multiplied by $17.46 per enrollee.

(b) For the December [2007] *2008* payments to MCOs meeting the requirements specified in §A of this regulation from July 1 through December 31, [2007] *2008*, 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 [2007] *2008*

prospectively for that MCO's December **[**2007**]** *2008* enrollment, multiplied by $17.46 per enrollee.

(4) (text unchanged)

C. (text unchanged)

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

A.—B. (text unchanged)

C. MCO Payment for **[**Physician**]** *Provider* Services.

(1) (text unchanged)

(2) Effective July 1, 2008, for inpatient services performed in hospitals, an MCO shall pay all providers, regardless of the provider's contracting status, at least the Medicaid fee-for-service rate.

[(2)**]** *(3)* (text unchanged)

.23 Marketing.

A.—C. (text unchanged)

D. Standards for Departmental Approval of MCO Advertising.

(1) MCO advertising **[**is to be**]** *shall:*

(a) Be based on documented fact;

(b) Identify all telephone numbers used that do not belong to the MCOs;

(c) Include the statement, " 'HealthChoice or PAC' is a program of the Maryland Department of Health and Mental Hygiene"; and

(d) Be at a fifth grade reading level.

(2) (text unchanged)

.24 Enhanced Dental Services Plan.

A. (text unchanged)

[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.] *B.* (text unchanged)

10.09.66 Maryland Medicaid Managed Care Program: Access

Authority: Health-General Article, §§15-102.1(b)(10) and 15-103(b), Annotated Code of Maryland

.01 Access Standards: Addressing Enrollees' Individualized Needs.

A. An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, including, but not limited to, the delivery of services and information to enrollees:

(1) In a culturally sensitive manner [that facilitates an understanding of the MCO's benefits package and how to access care, and generally enhances communication between enrollees and their health care providers];

(2) [With all written materials produced by the MCO for distribution to its enrollees written at] *At* an appropriate reading comprehension level [and in the enrollee's native language for enrollees who are members of a substantial minority]; [and]

(3) In the prevalent non-English languages identified by the State; and

[(3)] *(4)* (text unchanged)

B. (text unchanged)

.04 Access Standards: Information for Providers.

A. An MCO shall develop and issue to all of its PCP and specialty care providers a Medicaid requirements manual, including periodic updates as appropriate, and shall:

(1)—(3) (text unchanged)

(4) Inform the providers of the following *enrollee* appeal, grievance, and fair hearing procedures and time frames:

(a)—(e) (text unchanged)

(f) The provider's *right to* appeal [rights to challenge], *on the enrollee's behalf,* the failure of the MCO to cover a service.

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

.07 Benefits—Inpatient Hospital Services.

A.—G. (text unchanged)

H. Payment For Ancillary Services.

(1) Effective January 1, 2009, an MCO shall pay for all medically necessary ancillary services provided on inpatient hospital days including those days for which the inpatient hospitalization is otherwise appropriately denied.

(2) A denial of an inpatient ancillary service shall be based on the medical necessity of the specific ancillary service.

(3) An MCO is not required to pay for ancillary services if the entire hospitalization in §H(1) of this regulation is appropriately denied.

10.09.68 Maryland Medicaid Managed Care Program: School-Based Health Centers

Health-General Article, §15-103(b)(19)(i),
Annotated Code of Maryland

.03 Conditions for Reimbursement for Self-Referred Services.

A.—C. (text unchanged)

D. Required Timeliness of Reports to MCO.

(1) To receive reimbursement for self-referred school-based health center services, the school-based health center shall transmit to the MCO, within 6 months of performing the services, encounter data and billing information using the **[**HCFA 1500**]** *CMS1500* format.

(2) (text unchanged)

E.—F. (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

.01 [Consumer] *Enrollee* Services Hotline. An MCO shall:

A. Maintain a member services unit that operates [a consumer services] *an enrollee* hotline at least during normal business hours;

B. Operate its [consumer] *enrollee* services hotline as a triage device to handle or properly refer enrollees' questions or complaints; and

C. Provide an enrollee with information about how to use the MCO member services unit and [consumer] *enrollee* services hotline to obtain information and assistance.

.02 Internal Complaint Process for Enrollees.

A. (text unchanged)

B. An MCO shall:

(1) (text unchanged)

(2) Include as part of the written complaint procedures a form for the enrollee's use when filing [a] *an appeal or* grievance, and a process, which shall include providing interpreter services and toll-free numbers with TTY/TDD, by which an MCO staff member can assist in its completion;

(3)—(4) (text unchanged)

C. An MCO shall include in the internal complaint process the procedures for registering and responding to [complaints] *appeals* and grievances in a timely fashion, which:

(1)—(12) (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)—(2) (text unchanged)

(3) Documentation of the substance of complaints and [actions] *steps* taken;

(4)—(8) (text unchanged)

C. (text unchanged)

.05 Appeal Process for Enrollees.

A. An MCO's appeal process shall:

(1) Require that an enrollee, or a provider acting on the enrollee's behalf, file an appeal within **[**30**]** *90* days from the date on the MCO's notice of action;

(2)—(7) (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

.04 Departmental Complaint Resolution.

A. When a dispute between an enrollee and an MCO involving an action **[**cannot be**]** *is* resolved through the Department's enrollee complaint process, **[**including its ombudsman program,**]** the Department shall:

(1)—(2) (text unchanged)

B.—C. (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

.02 Procedures.

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

B.—E. (text unchanged)

10.09.76 Primary Adult Care Program

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

.03 Enrollment.

A.—D. (text unchanged)

E. Reassignment.

(1) **[**Before**]** *Sixty days before* the anniversary date of a PAC enrollee's initial MCO enrollment, the Department shall notify the enrollee **[**that the enrollee has 21 days to notify the Department of a decision to enroll in a new MCO**]** *of the annual right to change the enrollee's MCO.*

(2)—(6) (text unchanged)

.16 Data Collection and Reporting.

A. (text unchanged)

B. PAC Encounter Data. An MCO shall:

(1) Submit encounter data monthly in **[**CMS 1500**]** *CMS1500* and **[**UB92**]** *UB04* format or an alternative format previously approved by the Department;

(2)—(3) (text unchanged)

C.—G. (text unchanged)

JOHN M. COLMERS
Secretary of Health and Mental Hygiene