MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
MCO Transmittal No. 129
December 11, 2018

TO: Managed Care Organizations

FROM: Jill Spector, Director, HealthChoice and Acute Care Administration
Office of Health Services Jill Spector

RE: Medicaid and CHIP Managed Care Final Rule Provisions Effective January 1, 2019

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

In April 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid and CHIP Managed Care Final Rule which revised several existing Medicaid managed care regulations, with some requirements taking effect during contract periods beginning on or after July 1, 2018. Because Maryland's managed care contracts operate on a calendar year basis, the Department implemented the Final Rule provisions in COMAR effective January 1, 2019. The Department also implemented some other changes related to the managed care regulations. MCOs must comply with the following requirements:

Transition of Care
Upon request, an MCO whose member has disenrolled must transfer historical utilization data to the member's new MCO in the timeframe and format specified by the Department (COMAR 10.09.65.15K).

Network Adequacy and Access

- MCOs must ensure services are delivered in a culturally competent manner to all enrollees, including:
  - Enrollees with limited English proficiency;
  - Enrollees with diverse cultural and ethnic backgrounds; and
  - Enrollees of all genders, sexual orientations, and gender identities (COMAR 10.09.66.05B (6)(a)).
- For enrollees with physical or mental disabilities, MCOs must ensure its network providers provide physical access, reasonable accommodation, and accessible equipment. (COMAR 10.09.66.05B (6)(b)).
- MCOs must comply with either the new time or distance standards for certain network provider types set forth in COMAR 10.09.66.05-1A(3) and 10.09.66.06A (enclosed).
- If an MCO's provider network is unable to provide covered services to a particular enrollee, the MCO must adequately and timely cover these services out of network for as long as the MCO's provider network is unable to provide them. (COMAR 10.09.66.07D (3)).

Quality Assurance

- MDH removed postpartum care from the value based purchasing measures for calendar year 2019, due to changes in medical practice that may impact the measure (COMAR 10.09.65.03B(3)(f) and (h)).
- MCOs must participate in annual validation and evaluation of their MCO provider network to ensure compliance with the network adequacy standards set forth in COMAR 10.09.66 (COMAR 10.09.65.03B (7)).

Data Collection and Reporting

MCOs must submit encounter data that includes, at a minimum:

- Enrollee and provider identifying information;
- Service, procedure, and diagnoses codes;
- Allowed, paid, enrollee responsibility, and third party liability amounts; and
- Service, claims submission, adjudication, and payment dates (COMAR 10.09.65.15B (3)).

Eligibility/Enrollment

MCOs must ensure that all network providers have been screened, enrolled and periodically revalidated by the State as Medicaid providers in accordance with 42 CFR part 455, subparts B and E (COMAR 10.09.68.01N).

Medical Loss Ratio (MLR)

By September 15th of the second year following the MLR reporting year, each MCO must provide to the Department a completed Medical Loss Ratio (MLR) Reporting Template including the MCO attestation and any additional documentation supporting the MLR reporting template (COMAR 10.09.62.01 and 10.09.65.19-5).

State Fair Hearings

MCOs must comply with the requirements of the State fair hearing process, which has been moved to COMAR 10.09.71.05F, including:

- Providing documentation regarding medical determination to enrollees and the Office of Administrative Hearings (COMAR 10.09.71.05F(5)); and
- Continuing the enrollee's benefits pending the outcome of the State fair hearing if certain conditions occur (COMAR 10.09.71.05F (6)).

Complaints and Appeals

- MCOs must provide its enrollee services phone number on the required enrollee identification card (COMAR 10.09.71.01D).
- MCOs must submit an internal complaint process detailing the procedures for registering and responding to appeals and grievances in a timely fashion for Departmental approval (COMAR 10.09.71.02C).
- For member complaints, MCOs must:
  - Acknowledge an enrollee appeal or grievance reported to it by the Department's complaint resolution unit within 1 business day;
  - Respond to the Department's request for information regarding disputed non-emergency medical care actions within 3 business days;
  - Provide updates in a timeframe specified by the Department;
  - Provide medical records within 5 days of the request; and
  - Provide a corrective action plan upon request and within the timeframe specified but no later than 10 days from the date of the request (COMAR 10.09.71.02-1).
- MCOs must include notices to primary care providers informing them of the enrollee's right to change MCOs in their procedures for termination or withdrawal of a provider from the MCO's provider panel (COMAR 10.09.71.03B(5)(c)).

- For provider complaints, MCOs must:
    - Acknowledge provider grievances within 3 business days;
    - Provide findings to the Department within 5 days; and
    - Provide a corrective action plan to the Department within 10 days from the date of the request (COMAR 10.09.71.03-1).
- MDH repealed 10.09.72 in its entirety and updated regulations to reference the locations of the new information.
- MDH may order MCOs to provide a benefit or service to enrollees (COMAR 10.09.73.01A (6)).
- MDH repealed the section about penalties for MCO's failure to provide timely notice of wellness services (COMAR 10.09.73.01C).
- MCOs must comply with the revised procedures for appealing a sanction by MDH set forth in COMAR 10.09.73.02. Financial sanctions may no longer be stayed by filing an appeal.

If you have any questions regarding these policy changes, please contact Pam Williams, HealthChoice Administrator, at (410) 767-3532 or pam.williams@maryland.gov.

HEALTHCHOICE TIME AND DISTANCE STANDARDS

To comply with the requirements of 42 CFR 438.68, MDH is responsible for developing minimum time and distance standards for HealthChoice MCO provider networks. MDH developed these standards by adapting the Health Service Delivery (HSD) standards for Maryland Medicare Advantage plans and the current HealthChoice regional and distance network standards. For each provider type, MCOs meet either the time or distance standard for each county in the MCO's service area.

	Urban[1]		Suburban[2]		Rural[3]	
Provider Type	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)
Primary Care	15	10	30	20	40	30
Primary Care - Pediatric	15	10	30	20	40	30
Pharmacy	15	10	30	20	40	30
Diagnostic Laboratory/X-Ray	15	10	30	20	40	30
Gynecology	15	10	30	20	40	30
Prenatal Care[4]	15	10	30	20	90	75
Acute Inpatient Hospitals	20	10	45	30	75	60
Core Specialties (Cardiology, ENT, Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, Urology)	30	15	60	45	90	75
Major Specialties (Allergy and Immunology, Dermatology, Endocrinology, Infectious Diseases, Nephrology, Pulmonology)	30	15	80	60	110	90
Pediatric Sub-Specialties (Cardiology, Gastroenterology, Neurology, Surgery)	30	15	80	60	250	200

MONITORING AND ENFORCEMENT

HealthChoice MCOs will be required to give assurances to MDH annually, along with supporting documentation, demonstrating their provider network's capacity to serve enrollees in a format specified by MDH. When an MCO cannot demonstrate adequate coverage for 90% of enrollees in a service area at the required time or distance, MDH may freeze auto-assignments in the impacted service area.
When an MCO proposes expansion into a new county, MDH will evaluate their provider network according to the time and distance standards in that service area. If the MCO can demonstrate adequate coverage for 90% of enrollees at the required time or distance standards in the county for each provider type, MDH will allow the MCO to open in that county.

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[1] Urban Counties: Baltimore City

[2] Suburban Counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, Prince George's

[3] Rural Counties: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, Worcester

[4] Prenatal Care providers include obstetricians and certified nurse midwives. Family practitioners who provide prenatal care and deliveries may be considered in areas where there is a shortage of obstetricians.