

## HEALTHCHOICE MANAGED CARE ORGANIZATION AGREEMENT

THIS AGREEMENT (Agreement), effective January 1, 2021, is entered into by and between the Maryland Department of Health (Department) and \_\_\_\_\_ (MCO), a Managed Care Organization with authority to conduct business in the State of Maryland (State).

WHEREAS, the Department has established the Maryland Medicaid Managed Care Program, also known as the Maryland HealthChoice Program (HealthChoice), a waiver program approved by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) under §1115 of the Social Security Act and authorized under Maryland Annotated Code, Health-General Article, §§15-101 et seq.

WHEREAS, the Department desires to provide health care services to Medicaid recipients through the MCO.

WHEREAS, the MCO is engaged in the business of arranging and/or providing health care services.

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained, the parties hereto agree as follows:

### I. DEFINITIONS AND ACRONYMS

A. For the purposes of this agreement, the following terms have the meaning stated:

1. “Administrative Services Organization” means an organization that manages designated administrative functions while the entity contracting the organization retains the risks and liabilities.
2. “CRISP” means the designated regional health information exchange that serves Maryland and the District of Columbia.
3. “Department” means the Maryland Department of Health, as defined in COMAR 10.09.36.01, or its authorized agents acting on behalf of the Department.
4. “Direct and indirect remuneration fees” in PBM contracts may include but are not limited to:
  - a. Any pay-to-play for network participation;
  - b. Any fees for periodic reimbursement reconciliations to provide a true-up between a target reimbursement rate in a participating pharmacy agreement and the aggregated effective rate actually realized by a pharmacy or between the aggregate maximum

allowable cost (MAC) or adjudicated rate and the aggregate contracted rate; or

- c. Any payment mechanism to pharmacies for the fulfillment of quality measures or fee assessed to pharmacies for noncompliance with quality measures.
5. “Encounter Data” means information documenting a service to an Enrollee.
  6. “Enrollee” means a Medicaid recipient who is enrolled in a managed care organization.
  7. “Medically necessary services” means that the service or benefit is:
    - a. Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
    - b. Consistent with current accepted standards of good medical practice;
    - c. The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
    - d. Not primarily for the convenience of the consumer, the consumer's family, or the provider.
  8. “Medical loss ratio” means a formula that measures the ratio of MCO spending on medical and related benefits compared to revenue, to ensure that MCOs are spending a sufficient amount of their premium revenue on medical expenses and other high-impact initiatives.
  9. “MLR reporting year” means a period of 12 months consistent with the rating period selected by the Department.
  10. “Network provider” means a provider that is a member of the MCO’s provider panel. A network provider is not a subcontractor on the sole basis of its network provider agreement with the MCO.
  11. “Pharmacy benefit manager” means a third-party administrator of a prescription drug program for an MCO, including but not limited to network management, drug utilization review, outcome management, and disease management.

12. “Potential enrollee” means a recipient who is authorized by the Department to enroll in a managed care organization.
13. “Practice guidelines” means statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.
14. “Program” means the Medical Assistance Program.
15. “Recipient” means an individual who receives benefits under the State Medical Assistance Program.
16. “Self-referral services” are the health care services listed in COMAR 10.67.06.28 for which, under specified circumstances, the MCO is required to pay, without any requirement of referral by the PCP or MCO, when the enrollee accesses the service through a provider other than the enrollee's PCP.
17. “Spread pricing” means a form of reimbursement in which the pharmacy benefits manager (PBM) retains the difference between the amount the MCO pays the PBM and the amount the PBM reimburses the pharmacy for a drug and its associated costs. Spread pricing does not include the MCO paying the PBM reasonable administrative and transactional costs for services.
18. “State” means the State of Maryland.
19. “State Plan” means an agreement between the State and the Federal government describing how the State administers its Medicaid and CHIP programs. The State Plan includes the groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities underway in the State.
20. “Subcontractor” means an individual or entity that has a contract with an MCO that relates directly or indirectly to the performance of the MCO’s obligations under this contract. A network provider agreement with an MCO does not by itself make the network provider a “subcontractor” to an MCO.
21. “Third party liability” means the legal obligation of third parties (for example, certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third-party resources

must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

**B.** For the purposes of this agreement, the following terms will be addressed using the stated acronym:

1. ASO – Administrative Services Organization
2. COMAR – Code of Maryland Regulations
3. CMS – Centers for Medicare and Medicaid Services
4. CRISP – Chesapeake Regional Information System for our Patients
5. DHHS – U.S. Department of Health and Human Services
6. DPP – Diabetes Prevention Program
7. EPLS – Excluded Parties List System
8. E&M – Evaluation and Management
9. ePREP – Electronic Provider Revalidation and Enrollment Portal
10. FQHC – Federally Qualified Health Center
11. IRO – Independent Review Organization
12. LEIE – List of Excluded Individuals/Entities
13. MCO – Managed Care Organization
14. MHBE – Maryland Health Benefit Exchange
15. MLR – Medical Loss Ratio
16. M-QIP – Maryland Quality Incentive Program
17. NPPES – National Plan and Provider Enumeration System
18. OIG – Office of the Inspector General
19. PBM – Pharmacy Benefit Manager
20. SSA-DMF – Social Security Administration Death Master File
21. TPL – Third Party Liability
22. TTY/TDD – Teletypewriter/Telecommunication Device for the Deaf

## **II. THE MCO AGREES:**

### **A. General Requirements**

1. To comply with Maryland Annotated Code Health-General Article, Title 15 and the Insurance Article provisions referenced therein, the regulations of the HealthChoice Program (see Appendix M), several of which are specifically referenced herein, as well as 42 CFR Part 438, any other applicable provisions of federal law, the Maryland Code, COMAR, transmittals, and guidelines issued by the Department in effect at any time during the term of this Agreement.
2. Notwithstanding any other provision of this Agreement, to be subject to any change in Federal or State law or regulation, or other policy guidance from CMS or the Department that applies during the term of this Agreement. The MCO retains all rights available to challenge the authority or basis for any such changes.
3. To comply with the federal law provisions pertaining to Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), The Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 as amended, and section 1557 of the Patient Protection and Affordable Care Act, as well as the conflict of interest safeguards described in 42 CFR 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.
4. To comply with the requirements of section 5006 of the American Recovery and Reinvestment Act and all applicable federal guidance regarding the rights of Indian Enrollees.
5. To comply with the MCO's continuity of operations plan and disaster recovery plan, along with any directives from the State or the Department, in the event of a state of emergency (or other catastrophic event). This requirement includes keeping up to date the continuity of operations plan and disaster recovery plan, providing the plans to the Department upon request, and ensuring subcontractors maintain and deploy routinely updated continuity of operations plans and disaster recovery plans when necessary.

6. To execute or amend a State Providers' Amendment to HealthChoice Provider Service Agreements at the same time that the MCO executes a HealthChoice Provider Agreement with a county health department.
7. To comply with the provisions of this Agreement and all appendices contained therein.
8. To execute the Non-Exchange Entity Agreement with the Maryland Health Benefit Exchange (MHBE) and ensure the confidentiality, privacy and security of data accessed by the MCO or exchanged between the MCO and MHBE and compliance with the requirements of the ACA, including 45 CFR 155.260(b)(2) and 45 CFR 155.270(a).
9. To participate in federal grants awarded to the Department and federal grant application processes, including but not limited to the Maternal Opioid Misuse (MOM) Model (Appendix H).

#### **B. Enrollment & Disenrollment**

1. To accept enrollments of recipients authorized to enroll into an MCO by the Department and process enrollments in accordance with 42 CFR 438.54 and COMAR 10.67.02.02 (Appendix M).
2. To request disenrollment only for the reasons set forth in COMAR 10.67.02.06D (Appendix M) and 42 CFR 438.56.
3. To comply with the Department's disenrollment policies and procedures, which are set forth in COMAR 10.67.02.05 and 10.67.02.06 and 10.09.69.04 (Appendix M).
4. To submit to the Department, within thirty (30) days of the date the MCO receives the monthly enrollment listings from the Department, a list of Enrollees who are known to the MCO to have:
  - a. Disenrolled from the HealthChoice Program;
  - b. Relocated to a geographic area not serviced by the MCO;
  - c. Become ineligible to receive HealthChoice Program services from the MCO; or
  - d. Died.
5. To submit any additional information the Department requests about the Enrollees referenced in II.B.4 of this Agreement.

6. To process Enrollee updates provided by the Department in a timely manner, including but not limited to Enrollee demographic updates and Enrollee primary care provider selections.

**C. Enrollee Rights**

1. To permit each Enrollee to choose his or her network provider to the extent possible and appropriate, as set forth in COMAR 10.67.05.05 (Appendix M).
2. To provide practice guidelines to Enrollees and potential Enrollees upon request.
3. To accord Enrollees all the rights available to them under 42 CFR 438.100; to require their network providers to also respect those rights; and to develop written policies governing the protection of those rights.
4. To refrain from discriminating against or using any policy or practice that has the effect of discriminating against Enrollees on the basis of age, sex, gender identity, race, creed, color, marital status, sexual orientation, national origin, physical or mental handicap, health status, or need for health services.
5. Not to prohibit or otherwise restrict the advice that a health care professional, with a contractual, referral, or other arrangement with the MCO, gives to an Enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under this Agreement, if the professional is acting within the lawful scope of practice.
6. To comply with the requirements governing Enrollee appeals and grievances set forth in COMAR 10.67.09 (Appendix M) and 42 CFR 438, subpart F.
7. To provide the MCO enrollee services phone number on the identification card required in COMAR 10.67.04.02E (3).

**D. Covered Services**

1. To cover, for Enrollees:
  - a. In accordance with COMAR 10.67.06 and as defined in COMAR 10.67.01.01B (Appendix M), medically necessary covered services

under the Maryland Medicaid State Plan (State Plan) in the amount, duration and scope set forth in the State Plan and in accordance with 42 CFR 438.210 and 42 CFR 440.230.

- b. Any services that the MCO voluntarily agrees to provide, the cost of which cannot be included when determining the payment rates under this Agreement.
  - c. Any services necessary for compliance by the MCO with the requirements of subpart K of 42 CFR Part 438, to the extent such services are necessary for the MCO to comply with 42 CFR 438.910.
  - d. Any services or settings identified in Appendix E which are offered at the option of the MCO, or which are in-lieu-of services or settings covered under the State Plan, if:
    - i. The Department determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State Plan;
    - ii. The Enrollee is not required by the MCO to use the alternative service or setting;
    - iii. The utilization and actual cost of in-lieu-of services are taken into account when developing the component of the capitation rates that represents the covered State Plan services; and
    - iv. CMS approves the services identified in Appendix E as part of the submission of this Agreement.
2. To comply with requirements governing emergency and post-stabilization services under 42 CFR 438.114.
  3. To comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions, that are set forth in 42 CFR 434.6(a)(12) and 42 CFR 447.26, and to report all identified provider-preventable conditions in a form or frequency specified by the Department.

#### **E. Quality Improvement**

1. To implement an ongoing comprehensive quality assessment and performance improvement program for the services furnished to its Enrollees that includes, but is not limited to:



- a. Performance improvement projects in accordance with 42 CFR 438.330(d);
  - b. Collection and submission of performance measurement data in accordance with 42 CFR 438.330 (c);
  - c. Mechanisms to detect underutilization and overutilization of services; and
  - d. Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.
2. To participate in annual Quality Meetings with the Department to evaluate MCO performance and operations.
  3. To participate in all quality improvement activities listed in COMAR 10.67.04.03B (Appendix M).
  4. To participate in annual validation and evaluation of MCO provider networks.
  5. To comply with the Department's Network Adequacy Standards (Appendix F).
  6. To maintain NCQA accreditation, as set forth in 42 CFR §438.332(b) and COMAR 10.67.03.08 (Appendix M), and to provide the Department a copy of its most recent NCQA accreditation, including:
    - a. Accreditation status, survey type, and level;
    - b. Accreditation results, including:
      - i. Recommended actions or improvements,
      - ii. Corrective action plans, and
      - iii. Summaries of findings; and
    - c. Expiration date of accreditation.
  7. To cooperate with any corrective actions and intermediate sanctions arising from the Department's Performance Monitoring Policy (Appendix D).

**F. Service Authorization and Utilization Management**

1. To place appropriate limits on services for utilization control, provided that:

- a. The services furnished can reasonably achieve the purpose for which the services are provided;
  - b. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and
  - c. Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used.
2. To adopt, apply, review, and update any practice guidelines in accordance with the requirements of COMAR 10.67.03.09L (Appendix M) and 42 CFR 438.236, and to disseminate practice guidelines to all affected providers.
  3. To have in place, and follow (along with its contractors), written policies and procedures for the processing of requests for initial and continuing authorizations of services and have mechanisms to ensure consistent application of review criteria for authorization decisions, including consultations with specialists, as appropriate.
  4. To adhere to the requirements for service authorization and notification set forth in 42 CFR 438.210(d) and COMAR 10.67.09.04 (Appendix M).
  5. Pursuant to 42 CFR 438.3(i) and 422.208, not to make payment directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual Enrollee.
  6. To execute an agreement with the Department's Independent Review Organization vendor and comply with the standards set forth in COMAR 10.67.13 (Appendix M).

#### **G. Coordination of Care**

1. To coordinate care and deliver quality health care to the MCO's Enrollees by providing all necessary information to the Medicaid Program, its authorized agents, the Administrative Services Organizations with which the Department contracts and to any other entity as directed by the Department, in accordance with applicable federal and state confidentiality laws and regulations.

2. For Enrollees with behavioral health conditions, coordination of care should include but not be limited to:
  - a. Participation in monthly collective MCO medical directors' meetings and one-on-one MCO meetings with the ASO for care coordination,
  - b. Cooperation with the Department's high utilizer pilot program,
  - c. Assistance with the development and coordination of appropriate treatment plans for Enrollees,
  - d. Provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process,
  - e. Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and
  - f. Provider education for Enrollee identification and referrals to the ASO or core service agencies for behavioral health services,
3. To implement procedures to deliver care to and coordinate services for all Enrollees. These procedures must do the following:
  - a. Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee (e.g., a primary care provider);
  - b. Provide the Enrollee with information on how to contact their designated person or entity;
  - c. Coordinate the services the MCO furnishes to the Enrollee:
    - i. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
    - ii. With the services the Enrollee receives from any other MCO;
    - iii. With the services the Enrollee receives in FFS Medicaid; and
    - iv. With the services the Enrollee receives from community and social support providers.

- d. Make a best effort to conduct an initial screening of each Enrollee's needs, within 90 days of the effective date of enrollment for all new Enrollees, including subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful;
- e. Share with the Department or other MCOs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of services or benefits;
- f. Use CRISP to identify new Enrollees and their potential risk categories and to coordinate with other MCOs as appropriate for transition of care activities;
- g. Ensure that each provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards; and
- h. Ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

#### **H. Information Requirements**

- 1. To comply with all marketing requirements under 42 CFR 438.104 and COMAR 10.67.04.23 (Appendix M).
- 2. To comply with the rules, language, and format standards for Enrollee information set forth in 42 CFR 438.10(c) and (d) and COMAR 10.67.05.01 (Appendix M).
- 3. To provide Enrollees with the model Enrollee handbook developed by the Department and ensure it contains the minimum requirements outlined in 42 CFR 438.10(g)(2) and COMAR 10.67.05.02 (Appendix M).
- 4. To provide Enrollees with a network provider directory and ensure it contains the minimum information about physicians (including specialists), hospitals, and pharmacies outlined in 42 CFR 438.10(h)(1) and COMAR 10.67.05.02 (Appendix M).
- 5. To submit changes to Enrollee handbooks and Enrollee notices to the Department for review and approval prior to use and dissemination.

#### **I. Reporting Requirements**

1. To prepare and submit to the Department HealthChoice Financial Monitoring Reports in accordance with COMAR 10.67.04.15E (5) and 10.67.04.19-5 (Appendix M).
2. To submit to the Department the reports described in COMAR 10.67.07.03 (Appendix M).
3. To seek and obtain the Department's approval before making or allowing any material deviations in corporate structure, management, or operations from the MCO application and supporting documentation that was provided and approved pursuant to COMAR 10.67.03 (Appendix M).
4. To maintain a health information system that collects, analyzes, integrates, and reports data, including encounter data and that can achieve the objectives of 42 CFR 438, subpart D; and to comply with the requirements of 42 CFR 438.242(b) and (c) and COMAR 10.67.04.15 (Appendix M).
5. To submit encounter data that identifies the provider who delivers any items or services to enrollees at a frequency and level of detail to be specified by CMS and the Department, including, at a minimum:
  - a. Enrollee and provider identifying information;
  - b. Service, procedure, and diagnoses codes;
  - c. Allowed, paid, enrollee responsibility, and third-party liability amounts; and
  - d. Service, claims submission, adjudication, and payment dates.
6. To identify sub-capitated arrangements and denied claims in the 837 encounter data submissions (refer to the MDH 837 Encounter Companion Guides for the appropriate CN1 segment and data elements).
7. To submit to the Department a list of all State fair hearings held, and decisions rendered during the preceding quarter, within 10 calendar days after the close of each calendar quarter, in the format specified by the Department.
8. To transfer historical utilization data upon request for any members who have disenrolled from the MCO in the timeframe and format specified by the Department.

9. To submit information to the Department for a report due to CMS on or before October 1, 2021, and provide other information as needed to ensure ongoing compliance with 42 CFR 438, subpart K (applying parity standards from the Mental Health Parity and Addiction Equity Act), including engaging in the following:
  - a. Purchasing a license for and utilizing the ClearHealth Quality Institute (CHQI) Parity Manager Tool;
  - b. Providing comprehensive responses and completing all requested fields in the CHQI Parity Manager Tool and updating information on a quarterly basis; and
  - c. Responding to all follow-up requests by the Department for additional information.
10. To supply other information requested by the Department, given a reasonable period of notice, for the purposes of Maryland Medicaid Managed Care Program administration or the Department's monitoring of MCO performance pursuant to COMAR 10.67.04.15 (Appendix M).
11. To report third-party liability collection activities as described in 10.67.04.18 (Appendix M).

## **J. Financial Requirements**

1. To calculate and report a medical loss ratio for each rating year to the Department in the form and manner specified in 42 CFR 438.8 and §II.K of this Agreement.
2. To accept the capitation rates set forth in Appendix C (Managed Care Organization Service Areas and Reimbursement Rates) as payment for services rendered to Enrollees of the Maryland HealthChoice Program.
3. Value Based Purchasing
  - a. To participate in the Department's Value Based Purchasing program which, pursuant to 42 CFR 438.6(b)(2), shall be applicable only to the rating period under this Agreement.
  - b. Effective January 1, 2021, the core performance measures are:
    - i. Adolescent well care visits

- ii. Ambulatory care for SSI adults
  - iii. Ambulatory care for SSI children
  - iv. Asthma medication ratio
  - v. Breast cancer screening
  - vi. Comprehensive diabetes care — HbA1c control (<8.0%)
  - vii. Controlling high blood pressure
  - viii. Lead screening for children 12 through 23 months old
  - ix. Postpartum care
  - x. Well child visits in the first 15 months of life
- c. To agree to the following terms governing Value Based Purchasing:
- i. If a measure selected for Value Based Purchasing is substantially altered or retired, the Department may remove the measure and modify the Value Based Purchasing methodology based on the remaining measures.
  - ii. There will be three levels of performance; each measure will be evaluated separately and be of equal weight.
  - iii. On any measure the MCO fails to meet the disincentive target, a penalty of 1/10 of 1 percent of the MCO's total capitation payment will be collected, unless the provision in II.J.3.c.iii applies.
  - iv. If the Department's actuary determines the MCO's total capitation during the measurement year is not actuarially sound (see 42 CFR 438.4) after collection of the total penalty amount, the Department's actuary will calculate a penalty amount that would result in the MCO's capitation remaining actuarially sound, and the MCO may be subject to sanctions under COMAR 10.67.10 (Appendix M).
  - v. On any measure the MCO meets or exceeds the incentive target, the Department will pay 1/10 of 1 percent of the MCO's total capitation payment.

- vi. The total amount of the incentive payments will be paid with the total amount of the penalties collected from the MCOs for the measurement year, plus additional reserves from the HealthChoice Performance Incentive Fund if the total amount of the penalties collected is insufficient to pay the total amount of the incentive payments.
  - vii. The Department will distribute 40 percent of any funds remaining after the payment of incentives to the MCOs earning net incentives with the four highest normalized scores, at a rate calculated by multiplying each MCO's adjusted enrollment as of December 31 of the measurement year by a per enrollee amount. MCOs earning net disincentives are ineligible to receive these funds.
  - viii. The Department will distribute 25 percent of any funds remaining after the payment of incentives to MCOs that the Department determines have demonstrated performance improvement in the measurement year, provided the MCOs use the funding to target performance improvement in areas defined by the Department.
  - ix. The Department will retain 25 percent of any funds remaining after the payment of incentives for health improvement programs.
  - x. The Department will use 10 percent of any funds remaining after the payment of incentives to establish a reserve in the HealthChoice Performance Incentive Fund for any calendar year when the amount of penalties collected is insufficient to pay incentives earned by MCOs.
  - xi. If the amount in the HealthChoice Performance Incentive Fund exceeds \$5,000,000, the Department will equally allocate the remaining 10 percent of funds for use in II.J.3.c.vi–viii.
- 4. [To participate in the Department's stop-loss program in accordance with COMAR 10.67.04.22 (Appendix M) and to accept a stop-loss limit of \$150,000 per Enrollee.]
  - 5. To acknowledge the standards governing the Program's Rural Access Incentive Program set forth at COMAR 10.67.04.19-3 (Appendix M),



and to accept incentive payments developed in accordance with those regulations and 42 CFR 438.6 for the one-year rating period covered by this Agreement, subject to approval by the Department of Budget Management.

6. To accept as payment in full the amounts paid by the Department pursuant to Appendix C, and not to seek or accept additional payment from any Enrollee for any covered service; provided, however, that nothing in this Agreement shall prevent the MCO from seeking coordination of benefits or subrogation recoveries in accordance with applicable rules and regulations.
7. To refrain from making any expenditure for organ transplants, except as provided for in the State Plan and Section 1903(i) of the Social Security Act.
8. Except as provided in Section 1903(i) of the Social Security Act, to refrain from paying for any item or service furnished by any individual or entity to whom the State has failed to suspend payments under the State Plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with federal regulations, unless the State determines in accordance with such regulations there is good cause not to suspend such payment.
9. To refrain from making any expenditure with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or with any respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan and Section 1903(i) of the Social Security Act, except as provided for in Section 1903(i) of the Social Security Act.
10. To refrain from paying for an item or service (other than an emergency item or service) for home health care services provided by an agency or organization, unless the agency provides a surety bond as specified in Section 1861(o)(7) of the Social Security Act.
11. Not to hold Enrollees, the Department or DHHS liable for the debts of the MCO or any of its subcapitated providers in the event of the MCO's insolvency or the insolvency of its subcapitated provider, but nothing in this paragraph shall waive the MCO's right to be paid for the services that it has provided to its members.

12. Not to hold Enrollees or DHHS liable for the debts of the MCO for services provided to the Enrollee:
  - a. In the event that the MCO fails to receive payment from the Department for such services, or
  - b. In the event that a health care provider with a contractual, referral, or other arrangement with the MCO fails to receive payment from the Department or the MCO for such services.
13. To make payment to health care providers for items and services which are subject to this Agreement and that are furnished to the Enrollees on a timely basis consistent with the claims payment procedures described in section §1902(a)(37)(A) of the Social Security Act, 42 CFR 447.46 and the applicable provisions of 42 CFR 447.45, Maryland Annotated Code, Insurance Article, §15-1005 and Health-General Article, §15-102.3 unless the health care provider and the MCO agree to an alternate payment schedule.
14. To make pass-through payments to the Maryland Trauma Physician Services Fund, as set forth in Health General Article § 19-130(b)(2), Maryland Annotated Code.
15. To reimburse Maryland hospital providers based on rates approved by the Maryland Health Services Cost Review Commission (HSCRC).
16. To reimburse network providers for evaluation and management (E&M) codes at the Maryland Medicaid Fee-for-Service rates, at a minimum.
17. To reimburse self-referred services at the Maryland Medicaid Fee-for-Service rates, at a minimum.
18. To acknowledge and adhere to the HealthChoice Financial Sanction Policy, as outlined in Appendix I.
19. To participate in the Maryland Quality Incentive Program as described in Appendix J, contingent upon CMS approval.
20. To reimburse CDC-recognized organizations participating in the HealthChoice Diabetes Prevention Program at a rate equal to or greater than the rates specified in the fee schedule in Appendix K.

**K. Medical Loss Ratio**

1. To provide to the Department a completed MLR Reporting Template, including the MCO attestation and any additional documentation supporting the MLR reporting template (Appendix G), in accordance with 42 CFR 438.8, by November 15th of the calendar year following the MLR reporting year.
2. To provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent.
3. Newly contracted MCOs.
  - a. The Department may exclude a newly contracted MCO from MLR requirements for the first year of the MCO's operation.
  - b. Newly contracted MCOs shall comply with MLR reporting during the next MLR reporting year in which the MCO is operating, even if the first year was not a full 12 months.
4. To recalculate and resubmit the MLR report for all MLR reporting years affected if the Department makes retroactive changes to the capitation payments that impacts the MLR reporting year.
5. To attest to the accuracy of the calculation of the MLR when submitting its report to the Department.
6. To acknowledge the right to appeal a remittance being due to the Department within 30 days of notice, and that filing the appeal does not stay the obligation to remit the amount owed to the Department.

**L. Program Integrity**

1. To implement and require its responsible subcontractors to implement procedures that are designed to detect and prevent fraud, waste, and abuse set forth in 42 CFR 438.608 and COMAR 10.67.07 (Appendix M).
2. To designate a compliance officer, who reports directly to the chief executive officer and the board of directors and is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract, and at minimum the following staff members:

- a. An investigator who is responsible for fraud, waste, and abuse investigations;
  - b. An auditor who is responsible for identifying potential fraud, waste, and abuse through analysis of claims and related information; and
  - c. An analyst capable of reviewing data and codes who is responsible for reviewing and researching evidence of potential fraud, waste, and abuse.
3. To maintain staffing and resources located in Maryland to identify and investigate potential fraud, waste, and abuse, which shall be based on criteria determined by the Department that may include but are not limited to:
- a. Number of enrollees;
  - b. Number of claims received on an annual basis;
  - c. Volume of suspected fraudulent and abusive claims currently being detected;
  - d. Other factors relating to the vulnerability of the MCO to fraud and abuse; and
  - e. An assessment of optimal caseload which can be handled by an investigator on an annual basis.
4. To permit the Department, the Maryland Insurance Administration, and/or DHHS, or any of their respective designees, with respect to the MCO and any of its subcontractors, as required by 42 CFR 438.6(h), to:
- a. Evaluate the quality, appropriateness, and timeliness of services performed through inspection, or other means, including accessing the MCO and its subcontractors' facilities using enrollment cards and identities established in the manner specified by the Department; and
  - b. Inspect and audit any financial records, including but not limited to reimbursement rates.
5. To inform its subcontractors of the provisions of the Social Security Act §1128 B (Criminal Penalties for Acts Involving Federal Health Care Programs).

6. In accordance with Section 1903(m)(4)(B) of the Social Security Act, to report to the State and, upon request, to the Secretary or the Inspector General of the Department of Health and Human Services, the Comptroller General and Enrollees, a description of transactions between the MCO and a party in interest (as defined in section 1318(b) of The Public Health Service Act, including the following transactions:
  - a. Any sale, exchange, or leasing of any property between the MCO and such a party.
  - b. Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.
  - c. Any lending of money or other extension of credit between the MCO and such a party.
7. To comply with 42 CFR 438.610 by not knowingly having as a director, officer, partner, owner of more than five percent (5%) of the MCO's equity, a network provider, or a person with an employment, consulting, or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its Agreement with the Department, who is:
  - a. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549;
  - b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph HH(1) above; or
  - c. An individual or entity that is excluded from participation in any Federal health care program under sections 1128 or 1128A of the Social Security Act.
8. To acknowledge the sanction provisions under 42 CFR, Part 438, Subpart I, in Health-General Article §15-103(b)(9), and COMAR 10.67.10.01 (Appendix M).
9. To search the DHHS-OIG's List of Excluded Individuals/Entities, the General Services Administration Excluded Parties List System, the Social Security Administration Death Master File, and the National Plan & Provider Enumeration System for individuals excluded from

the Medicaid Program. Searches shall be done upon execution of this Agreement, and the LEIE and EPLS shall be checked at least monthly thereafter, using the names of all contracted individuals and entities, those with an ownership or control interest, and their agents and managing employees, in accordance with 42 CFR 455.436.

10. To create and manage mechanisms to conduct verifications with Enrollees whether services billed by network providers were received and provide evidence of verification efforts to the Department at least annually.
11. To require MCO program integrity representatives to attend in-person meetings with the Department and report ongoing efforts to detect and prevent fraud, waste, and abuse.
12. To identify and collect monies owing from responsible third parties liable for the cost of medical care furnished by the MCO to Enrollees in accordance with COMAR 10.67.04.18 (Appendix M).
13. To create and manage mechanisms to detect fraud and abuse and report to the Department's Office of the Inspector General (OIG), in accordance with OIG protocols.

#### **M. Subcontractors**

1. To comply with the requirements for the service or activity delegated under the subcontract set forth in 42 CFR 438.230 and COMAR 10.67.04.17 (Appendix M).
2. To structure compensation to subcontractors conducting utilization management activities so as not to provide incentives for denying, limiting, or discontinuing medically necessary services to any Enrollee, in accordance with 42 CFR 438.210(e).
3. To use the Department's Ownership and Control Disclosure Form to collect ownership and control, business transaction, and criminal conviction information from the MCO's subcontractors and delegated vendors, and to furnish that information to the Department upon request.

#### **N. Network Providers**

1. To demonstrate, in accordance with 42 CFR 438.207, COMAR 10.67.03.05, COMAR 10.67.05.05, and COMAR 10.67.05.05-1 (Appendix M) that the MCO:
  - a. Offers an appropriate range of preventive, primary care, and specialty services adequate for the anticipated number of Enrollees in the MCO's service areas.
  - b. Maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the number of Enrollees in the MCO's service areas.
  - c. Ensures that in-plan individual practitioners, based on full-time equivalency, are assigned no more than the number of enrollees that is consistent with a 200:1 ratio of enrollee to practitioner in the local access area.
  - d. Meets the Department's Network Adequacy Standards (Appendix F) in each service areas the MCO plans to enter or is enrolled.
  - e. Demonstrates to the Department's satisfaction the adequacy of its provider network if it cannot meet the Network Adequacy Standards, by providing evidence and assurances of the overall strength of the MCO's network and that the network will enhance recipients' overall access to quality health care services in the area to be served.
2. To maintain written policies and procedures for selecting and retaining network providers in accordance with the requirements of 42 CFR 438.214 and the applicable provider panel provisions of Maryland Insurance Article § 15-112, Code Ann.
3. To ensure that all its network providers are screened, enrolled, and revalidated by the State as Medicaid providers, in accordance with 42 CFR part 455, subparts B and E, and validate enrollment by verifying against the Department's full fee-for-service provider file.
4. To require that network providers enroll and comply with the requirements of the Department's Electronic Provider Revalidation Enrollment Portal (ePREP) in accordance with 42 CFR 438, subpart H.
5. To validate that any network provider rendering or receiving payment for covered services is enrolled and active on the date(s) of service by verifying against the full fee-for-service provider enrollment file from the Department.

6. To accept the Maryland Uniform Credentialing Form for the credentialing of network providers.
7. To refrain from discriminating against providers serving high-risk populations or specializing in conditions requiring costly treatment.
8. To inform all providers at the time of entering into a contract with the MCO about the grievance and appeal system, as set forth in 42 CFR 438.414 and 42 CFR 438.10(g)(2)(xi).
9. To monitor the Department's correspondence and any database publicizing Department-initiated terminations of providers from the Program.
10. To terminate the contract of, or refrain from contracting with, providers terminated or excluded from participating in the Program.
11. To develop and distribute a provider manual that includes all of the information provided in the Department's template and required in COMAR 10.67.05.04A(2).
12. To ensure services are delivered in a culturally competent manner to all Enrollees, including:
  - a. Enrollees with limited English proficiency;
  - b. Enrollees with diverse cultural and ethnic backgrounds; and
  - c. Enrollees of all genders, sexual orientations, and gender identities.
13. To ensure its provider network can provide physical access, reasonable accommodation, and accessible equipment for Enrollees with physical or mental disabilities.
14. To provide necessary services covered under the contract out of network adequately and timely for Enrollees, for as long as the MCO's provider network is unable to provide them.

**O. MCO Appeal Rights**

1. To acknowledge its right to appeal under the following grounds:
  - a. Decision to terminate the MCO's participation in the Maryland Medicaid Managed Care Program;



- b. Decision to impose a fine or other sanction on the MCO as described in COMAR 10.67.10.01;
  - c. Order to provide benefits or services to Enrollees;
  - d. Order that the MCO is impaired or in “hazardous financial condition;”
  - e. An adverse decision by the IRO as described in COMAR 10.67.13.08;
  - f. The amount of a penalty or incentive as described in COMAR 10.67.04.03;
  - g. The denial of a hepatitis C payment as described in COMAR 10.67.04.19;
  - h. Overpayments recovered by the Department;
  - i. Remittances to the Department related to MLR reporting.
- 2. To appeal to the Office of Administrative Hearings as specified in COMAR 10.09.36.09 and COMAR 10.01.03 (Appendix M).
  - 3. To acknowledge and agree that the following sanctions take effect immediately and are not subject to stay during the pendency of an appeal:
    - a. Any fines imposed;
    - b. Orders to provide a benefit or service to Enrollees;
    - c. Any full or partial withhold of the capitation payment;
    - d. Any remittances to the Department related to MLR; or
    - e. Any overpayments recovered by the Department related to program integrity efforts, as described in COMAR 10.67.07.01.

**P. Pharmacy**

- 1. To maintain drug review and utilization requirements that comply with 42 USC 1396a (oo), excluding sections (1)(A)(i)(III) and (B).
- 2. To cover outpatient drugs as defined in § 1927(k)(2) of the Social Security Act and comply with the requirements outlined in 42 CFR 438.3(s).

3. To provide coverage for medically necessary antiretroviral drugs used to treat and/or prevent HIV/AIDS, in accordance with the American Hospital Formulary Service therapeutic class 8:18:08.
4. Pharmacy Benefit Managers (PBMs)
  - a. To disclose for each pharmaceutical claim the amount the MCO paid the PBM, and of that amount, the amount paid to the pharmacy, including identifying the dispensing fee and the ingredient cost (if applicable), in a format and frequency determined by the Department.
  - b. To base PBM reimbursement on the actual amount paid by the PBM to a pharmacy for dispensing and ingredient costs.
  - c. To manage or delegate to the PBM any drug pricing appeals from pharmacies and resolve all appeals within 21 days of receipt of the request to review.
  - d. To comply with the requirements in Ins. Art. 15-1611.1 and Ins. Art. 15-1628.3.
  - e. To require PBMs to consider both ingredient costs and dispensing fees when determining reimbursement to pharmacies.
  - f. To comply with the prohibition of spread pricing reimbursement in PBM contracting.
5. To comply with the Department's opioid drug utilization review policies and its corrective managed care regulations set forth in COMAR 10.67.12 (Appendix M), including but not limited to providing provider education about prescribing limits, applying prior authorization requirements, and submitting reports to the Department upon request.
6. To require the PBM to comply with the following prohibitions by the end of the Agreement term, which do not preclude the reprocessing of claims due to claims adjudication errors made by the MCO, PBM, or an agent of either entity:
  - a. To prohibit the PBM from collecting direct or indirect remuneration fees, membership fees, or similar fees from pharmacies or other contracted entities acting on behalf of pharmacies as a condition of claims payment or network inclusion.

- b. To prohibit the PBM from implementing retrospective remuneration models, including but not limited to Generic Effective Rates (GERs) and Brand Effective Rates (BERs).
7. To comply with the Department's high cost low volume drug policy (Appendix L-1) and Hepatitis C risk pool reimbursement method (Appendix L-2).
8. To establish an annual audit process to review the performance of the PBM in the following areas, at a minimum:
  - a. Claims processing
  - b. Payment methodology
  - c. Allowable adjustments
9. To require in the PBM contract the hiring of an independent third party to complete an annual Service Organization Controls report (SOC-2, type 2) audit over the PBM's services and activities by the end of the Agreement term.
10. To submit summary reports of the annual audit findings of the audits required under (8) and (9), including any corrective actions that the MCO will mandate of their PBM, in the event issues have been identified by the audit.
11. To submit unredacted agreements between the MCOs and their PBMs to MDH.
12. To disclose to the Department the supplemental rebates allocation methodology between the PBM and the MCO.
13. To disclose to the Department all supplemental rebate revenue from the PBM on the HealthChoice Financial Monitoring Report.

### **III. THE DEPARTMENT AGREES:**

#### **A. General Requirements**

1. To pay the MCO in accordance with COMAR and Appendix C, which may be amended throughout the term of the Agreement.
2. To develop capitation rates that are:

- a. Actuarially sound so as to allow the MCO to effectively deliver covered services to Enrollees in a manner compliant with the requirements of this Agreement and 42 CFR 438.4 through 438.7, and 438.602(i); and
  - b. Based only upon services covered under the State Plan and additional services deemed by the State to be necessary to comply with the requirements of 42 CFR 438, subpart K of this part (applying parity standards from the Mental Health Parity and Addiction Equity Act).
3. To develop Value Based Purchasing and Rural Access incentive payments in accordance with the standards set forth in 42 CFR 438.6(b)(1).
4. [To develop stop-loss insurance in accordance with the standards set forth in 42 CFR 438.4 and 438.5.]
5. To produce and make available to the MCO on a monthly basis remittance advice and the following reports:
  - a. MCO Capitation Detail Report;
  - b. MCO Capitation Summary Report;
  - c. MCO Capitation Report by Rate Group;
  - d. MCO Capitated Enrollment Report;
  - e. MCO Capitated Enrollment Summary;
  - f. MCO Disenrollment Report by Site;
  - g. MCO Capitated Disenrollment Summary;
  - h. Zip Code Totals within MCO by Provider;
  - i. MCO Eligibility and Enrollment Renewal Files; and
  - j. Enrollee Bad Address File.
6. To include in the monthly enrollment listings sent to the MCO the adjustments provided by the MCO and accepted by the Department, and other appropriate debit and credit transactions.
7. To provide to the MCO at least 15 days' notice of any policy changes.
8. To make the accreditation status for the MCO available on the Website as required under 42 CFR 438.10(c)(3), including whether the MCO

has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually.

**B. Monitoring Requirements**

1. To review the ownership and control disclosures submitted by the MCO and those of any of the MCO's subcontractors, upon request.
2. To collect (including through its agents and contractors) the following information from the MCO to improve the performance of the managed care program, including at a minimum:
  - a. Enrollment and disenrollment trends in the MCO;
  - b. Member grievance and appeal logs;
  - c. Provider complaint and appeal logs;
  - d. Findings from the State's External Quality Review process;
  - e. Results from any Enrollee or provider satisfaction survey conducted by the State or MCO;
  - f. Performance on required quality measures;
  - g. Medical management committee reports and minutes;
  - h. The annual quality improvement plan for the MCO;
  - i. Audited financial and encounter data submitted by the MCO;
  - j. The medical loss ratio summary reports required by 42 CFR 438.8; and
  - k. Customer service performance data submitted by the MCO and performance data submitted by the beneficiary support system.

**C. Prevalent Non-English Languages**

1. To specify that, at the time of this Agreement, the prevalent non-English languages spoken by Enrollees and potential Enrollees in the State are as follows:
  - a. Amharic
  - b. Arabic
  - c. Bassi

- d. Chinese
- e. Farsi
- f. French
- g. Gujarati
- h. Haitian Creole
- i. Igbo
- j. Korean
- k. Portuguese
- l. Russian
- m. Spanish
- n. Tagalog
- o. Urdu
- p. Vietnamese
- q. Yoruba

**D. Imposition of Sanctions**

1. To give the MCO timely written notice explaining the basis and nature of any sanctions imposed, in accordance with COMAR 10.67.10.01A (Appendix M). Sanctions may include, but are not limited to:
  - a. Fines;
  - b. Suspension of further enrollment;
  - c. Withholding all or part of the capitation payment;
  - d. Termination of the Agreement;
  - e. Disqualification from future participation in the Maryland Medicaid Managed Care Program; and
  - f. Those actions outlined in 42 CFR 438.700–438.708, as amended.
2. To provide the MCO notice of appeal rights under COMAR 10.67.10.02 (Appendix M).
3. To permit the MCO the opportunity to take corrective action in accordance with a plan approved by the Department and with COMAR 10.67.10.01B (Appendix M).

**IV. THE DEPARTMENT AND THE MCO MUTUALLY AGREE:**

**A. Contract Term and Grounds for Termination**

1. That the term of this Agreement shall begin on January 1, 2021 and terminate on December 31, 2021.
2. That the MCO shall provide written notification to the Department of the MCO's intent to terminate this agreement for any future calendar year by October 1 of the prior year.
3. That the Department reserves the right to terminate this Agreement upon:
  - a. Completion or termination of the Section 1115 Research and Demonstration Waiver and Federal funding thereunder;
  - b. Notification by the Maryland Department of Budget and Management that State funds are not available for the continuation of the HealthChoice Program;
  - c. Determination that the MCO or any agent or employee of the MCO, or any person with an ownership interest in the MCO, or a related party of the MCO, has failed to comply with any applicable law, regulation, or Agreement term, or for other good cause shown, pursuant to COMAR 10.67.10 (Appendix M); or
  - d. Determination by the Department of insufficient MCO participation in the HealthChoice Program.
4. That if the Department terminates this Agreement for any reason, it shall not be liable for any costs of the MCO associated with the termination, including but not limited to, any expenditures made by the MCO prior to the termination or related to implementing the termination.
5. That termination of this Agreement shall not discharge the obligations of the MCO with respect to services or items furnished prior to termination, including payment for covered services delivered during the Agreement period, retention of records and restitution to the Department of overpayments.
6. That in the event of the termination of this Agreement either by the Department or by the MCO, the MCO will furnish to the Department all information relating to the reimbursement of any outstanding claims for services rendered to its Enrollees, including those of its subcontractors, within forty-five (45) days of the effective date of termination.

7. That prior to termination of this Agreement by the Department, the Department shall provide a pre-termination hearing in accordance with 42 CFR 438.710(b).

## **B. Payment**

1. That there will be a two-sided risk corridor for CY 2021 centered around a 1.6% profit margin as described in Appendix C.
2. That, with the exception of new Enrollees during the period of time between ten days after the Department's enrollment agent has notified the MCO of a new enrollment and receipt by the MCO of the Department's next regular monthly payment of capitation payment rates, the MCO is not required to pay for or provide services for any Enrollee for which it has not received a prepaid capitation rate from the Department.
3. That payments made under this Agreement will be denied for new Enrollees enrolled after imposition of such sanction as authorized by 42 CFR §438.702(a)(5):
  - a. When the Department determines that the MCO has acted or failed to act as described in 42 CFR §438.700(b)-(d); and
  - b. Until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

## **C. Miscellaneous**

1. That the MCO and the Department shall enter into a data use agreement with University of Maryland, Baltimore County acting through its Hilltop Institute, to facilitate the secure transmission of data to the Department's data warehouse.
2. That this Agreement may be modified only in writing by the parties.
3. That this Agreement shall not be transferable or assignable.
4. That any change in Federal or State law or regulation that affects any provision or term of this Agreement shall automatically become a provision or term of this Agreement.
5. That they shall carry out their mutual obligations as herein provided in a manner prescribed by law and in accordance with all applicable regulations and policies as may from time to time be promulgated by



DHHS or any other appropriate Federal or State agency, including compliance with the Agreement provisions or conditions required in all procurement contracts and subcontracts as specified under 45 CFR Part 74.

- 6. That a notice required to be given to the other party under this Agreement, unless specified otherwise, is effective only if the notice is provided in writing and sent by first-class mail, courier or delivery service, or electronic transmittal of original documents with signatures, to the representative and address for that party listed below:

- a. Notices to the Department shall be sent to:

Monchel Pridget  
Deputy Director, Managed Care Administration  
Maryland Department of Health  
201 W. Preston Street, Room 214A  
Baltimore, MD 21201  
[monchel.pridget@maryland.gov](mailto:monchel.pridget@maryland.gov)

- b. Notices to the MCO shall be sent to:

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IN WITNESS WHEREOF, the parties hereto have hereunder executed this Agreement the day and year first above written.

FOR THE DEPARTMENT:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tricia Roddy, Assistant Medicaid Director  
Office of Health Care Financing  
Maryland Department of Health

FOR THE MCO:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_

\_\_\_\_\_

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

\_\_\_\_\_  
Assistant Attorney General

\_\_\_\_\_  
Date

## BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the “Agreement”) is made by and between the Office of Health Care Financing, a unit of the Maryland Department of Health (MDH) (herein referred to as “Covered Entity”) and \_\_\_\_\_ (hereinafter known as “Business Associate”). Covered Entity and Business Associate shall collectively be known herein as the “Parties.”

WHEREAS, Covered Entity has a business relationship with Business Associate that is memorialized in a separate agreement (the “Underlying Agreement”) pursuant to which Business Associate may be considered a “business associate” of Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 including all pertinent privacy regulations (45 C.F.R. Parts 160 and 164) and security regulations (45 C.F.R. Parts 160, 162, and 164), as amended from time to time, issued by the U.S. Department of Health and Human Services as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5), and the HIPAA Omnibus Final Rule of 2013 (collectively, “HIPAA”); and

WHEREAS, the nature of the contractual relationship between Covered Entity and Business Associate may involve the exchange of Protected Health Information (“PHI”) as that term is defined under HIPAA; and

WHEREAS, for good and lawful consideration as set forth in the Underlying Agreement, Covered Entity and Business Associate enter into this Agreement for the purpose of ensuring compliance with the requirements of HIPAA and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq.*) (“MCMRA”); and

WHEREAS, this Agreement supersedes and replaces any and all Business Associate Agreements the Covered Entity and Business Associate may have entered into prior to the date hereof;

NOWHEREFORE, the premises having been considered and with acknowledgment of the mutual promises and of other good and valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

### I. DEFINITIONS

A. Catch-all definition. The following terms used in this Agreement, whether capitalized or not, shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

B. Specific definitions:

1. Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 C.F.R. § 160.103, and in reference to the party to this Agreement, shall mean \_\_\_\_\_, the managed care organization (MCO).
2. Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 C.F.R. § 160.103, and in reference to the party to this Agreement shall mean Office of Health Care Financing.
3. HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.
4. Protected Health Information (“PHI”). Protected Health Information or “PHI” shall generally have the same meaning as the term “protected health information” at 45 C.F.R. § 160.103.

## **II. PERMITTED USES AND DISCLOSURES OF PHI BY BUSINESS ASSOCIATE**

- A. Business Associate may only use or disclose PHI as necessary to perform the services set forth in the Underlying Agreement or as required by law.
- B. Business Associate agrees to make uses and disclosures and requests for PHI consistent with Covered Entity’s policies and procedures regarding minimum necessary use of PHI.
- C. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity.
- D. Business Associate may, if directed to do so in writing by Covered Entity, create a limited data set as defined at 45 C.F.R. § 164.514(e)(2), for use in public health, research, or health care operations. Any such limited data sets shall omit any of the identifying information listed in 45 C.F.R. § 164.514(e)(2). Business Associate will enter into a valid, HIPAA-compliant Data Use Agreement as described in 45 C.F.R. § 164.514(e)(4), with the limited data set recipient. Business Associate will report any material breach or violation of the data use agreement to Covered Entity immediately after it becomes aware of any such material breach or violation.
- E. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration or legal responsibilities of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

- F. The Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an individual pursuant to §§ 13405(d)(1) and (2) of the HITECH Act. This prohibition does not apply to the State's payment of Business Associate for its performance pursuant to the Underlying Agreement.
- G. The Business Associate shall comply with the limitations on marketing and fundraising communications provided in § 13406 of the HITECH Act in connection with any PHI of individuals.

### **III. DUTIES OF BUSINESS ASSOCIATE RELATIVE TO PHI**

- A. Business Associate agrees that it will not use or disclose PHI other than as permitted or required by the Agreement, the Underlying Agreement, the MCMRA, as Required by Law, or as authorized by Covered Entity, so long as the authorized use or disclosure is permitted by law.
- B. Business Associate agrees to use appropriate administrative, technical and physical safeguards to protect the privacy of PHI.
- C. Business Associate agrees to use appropriate safeguards, and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement;
- D.
  1. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including Breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware without unreasonable delay and in no case later than fifteen (15) calendar days after the use or disclosure.
  2. If the use or disclosure amounts to a breach of unsecured PHI, the Business Associate shall ensure its report:
    - a. Is made to Covered Entity without unreasonable delay and in no case later than fifteen (15) calendar days after the incident constituting the Breach is first known, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this Section III.D.1, Business Associate must notify Covered Entity of an incident involving the acquisition, access, use or disclosure of PHI in a manner not permitted under 45 C.F.R. Part E within fifteen (15) calendar days after an incident even if Business Associate has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA;
    - b. Includes the names of the Individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach;
    - c. Is in substantially the same form as Exhibit A hereto.

- E. In addition to its obligations in Sections III. A-D, within 30 calendar days after the incident constituting the Breach is first known, Business Associate shall provide to Covered Entity a draft letter for the Covered Entity to review and approve for use in notifying the Individuals that their Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach that includes , to the extent possible:
1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
  2. A description of the types of Unsecured PHI that were involved in the Breach (such as full name, Social Security number, date of birth, home address, account number, disability code, or other types of information that were involved);
  3. Any steps the affected Individuals should take to protect themselves from potential harm resulting from the Breach;
  4. A brief description of what the Business Associate is doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches; and
  5. Contact procedures for the affected Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address.
- F. In the event the Breach occurs through the fault of Business Associate, Business Associate shall be responsible for notifying Individuals by sending via First Class U.S. Mail the approved letter described in Section III(E) no later than 60 calendar days after discovery of the Breach.
- G. In the event the Breach occurs through the fault of Covered Entity, Covered Entity shall be responsible for notifying Individuals no later than 60 calendar days after Covered Entity receives notice of the Breach from the Business Associate.
- H. To the extent permitted by the Underlying Agreement, Business Associate may use agents and subcontractors. In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2) shall ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information, Business Associate must enter into Business Associate Agreements with subcontractors as required by HIPAA;
- I. Business Associate agrees it will make available PHI in a designated record set to the Covered Entity, or, as directed by the Covered Entity, to an individual, as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.524, including, if requested, a copy in electronic format;
- J. Business Associate agrees it will make any amendment(s) to PHI in a designated record set as directed or agreed to by the Covered Entity pursuant to 45 C.F.R. § 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.526;

- K. Business Associate agrees to maintain and make available the information required to provide an accounting of disclosures to the Covered Entity or, as directed by the Covered Entity, to an individual, as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.528;
- L. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s);
- M. Business Associate agrees to make its internal practices, books, and records, including PHI, available to the Covered Entity and/or the Secretary of HHS for purposes of determining compliance with the HIPAA Rules.
- N. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

#### IV. TERM AND TERMINATION

- A. Term. The Term of this Agreement shall be effective as of the effective date of the HealthChoice Managed Care Organization Agreement, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or the PHI created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, in accordance with the termination provisions in this Section IV, or on the date the Covered Entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner. If it is impossible to return or destroy all of the PHI provided by Covered Entity to Business Associate, or the PHI created or received by Business Associate on behalf of Covered Entity, Business Associate's obligations under this contract shall be ongoing with respect to that information, unless and until a separate written agreement regarding that information is entered into with Covered Entity.
- B. Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate, Covered Entity shall:
  - 1. Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement; or
  - 2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and Covered Entity determines or reasonably believes that cure is not possible.

C. Effect of Termination.

1. Upon termination of this Agreement, for any reason, Business Associate shall return or, if agreed to by Covered Entity, destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that the Business Associate still maintains in any form. Business Associate shall retain no copies of the PHI. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.
2. Should Business Associate make an intentional or grossly negligent Breach of PHI in violation of this Agreement or HIPAA or an intentional or grossly negligent disclosure of information protected by the MCMRA, Covered Entity shall have the right to immediately terminate any contract, other than this Agreement, then in force between the Parties, including the Underlying Agreement.

D. Survival. The obligations of Business Associate under this Section shall survive the termination of this agreement.

**V. CONSIDERATION**

Business Associate recognizes that the promises it has made in this Agreement shall, henceforth, be detrimentally relied upon by Covered Entity in choosing to continue or commence a business relationship with Business Associate.

**VI. REMEDIES IN EVENT OF BREACH OF AGREEMENT**

Business Associate hereby recognizes that irreparable harm will result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associate of any of the covenants and assurances contained in this Agreement. As such, in the event of breach of any of the covenants and assurances contained in Sections II or III above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of Sections II or III. Furthermore, in the event of breach of Sections II or III by Business Associate, Covered Entity is entitled to reimbursement and indemnification from Business Associate for Covered Entity's reasonable attorneys' fees and expenses and costs that were reasonably incurred as a proximate result of Business Associate's breach. The remedies contained in this Section VI shall be in addition to, not in lieu of, any action for damages and/or any other remedy Covered Entity may have for breach of any part of this Agreement or the Underlying Agreement or which may be available to Covered Entity at law or in equity.

**VII. MODIFICATION; AMENDMENT**



This Agreement may only be modified or amended through a writing signed by the Parties and, thus, no oral modification or amendment hereof shall be permitted. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA rules and any other applicable law.

#### **VIII. INTERPRETATION OF THIS AGREEMENT IN RELATION TO OTHER AGREEMENTS BETWEEN THE PARTIES**

Should there be any conflict between the language of this Agreement and any other contract entered into between the Parties (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

#### **IX. COMPLIANCE WITH STATE LAW**

The Business Associate acknowledges that by accepting the PHI from Covered Entity, it becomes a holder of medical information under the MCMRA and is subject to the provisions of that law. If the HIPAA Privacy or Security Rules and the MCMRA conflict regarding the degree of protection provided for PHI, Business Associate shall comply with the more restrictive protection requirement.

#### **X. MISCELLANEOUS**

- A. Ambiguity. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules.
- B. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.
- C. Agency. The Business Associate or Subcontractor is acting as an independent contractor and not as the agent of the Covered Entity or Business Associate. This Agreement does not give the Covered Entity or Business Associate such control over operational activities so as to make the Business Associate the agent of the Covered Entity, or the Subcontractor the agent of the Business Associate.
- D. No Private Cause of Action. This Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Agreement, as a result of any claim arising out of the Breach of this Agreement, the HIPAA Standards, or other state or federal law or regulation relating to privacy or confidentiality.
- E. Notice to Covered Entity. Any notice required under this Agreement to be given to Covered Entity shall be made in writing to:

Ramiak James, Esq.  
Privacy Officer and Compliance Analyst  
Maryland Department of Health  
Office of the Inspector General  
201 W. Preston Street, Floor 5  
Baltimore, MD 21201-2301  
Phone: (410) 767-5411

F. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to:

Address: \_\_\_\_\_  
\_\_\_\_\_  
Attention: \_\_\_\_\_  
Phone: \_\_\_\_\_

G. Survival. Any provision of this Agreement which contemplates performance or observance subsequent to any termination or expiration of this contract shall survive termination or expiration of this Agreement and continue in full force and effect.

H. Severability. If any term contained in this Agreement is held or finally determined to be invalid, illegal, or unenforceable in any respect, in whole or in part, such term shall be severed from this Agreement, and the remaining terms contained herein shall continue in full force and effect, and shall in no way be affected, prejudiced, or disturbed thereby.

I. Terms. All of the terms of this Agreement are contractual and not merely recitals and none may be amended or modified except by a writing executed by all parties hereto.

J. Priority. This Agreement supersedes and renders null and void any and all prior written or oral undertakings or agreements between the parties regarding the subject matter hereof.

IN WITNESS WHEREOF and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

**COVERED ENTITY:**

**BUSINESS ASSOCIATE:**

By: \_\_\_\_\_

By: \_\_\_\_\_

Name: Tricia Roddy

Name: \_\_\_\_\_

Title: Assistant Medicaid Director, Office of Health Care Financing

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**EXHIBIT A**

**FORM OF NOTIFICATION TO COVERED ENTITY OF  
BREACH OF UNSECURED PHI**

This notification is made pursuant to Section III.2.D(3) of the Business Associate Agreement between the Office of Health Care Financing, a unit of the Maryland Department of Health (MDH), and \_\_\_\_\_ (Business Associate).

Business Associate hereby notifies MDH that there has been a breach of unsecured (unencrypted) protected health information (PHI) that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: \_\_\_\_\_  
\_\_\_\_\_

Date of the breach: \_\_\_\_\_

Date of discovery of the breach: \_\_\_\_\_

Does the breach involve 500 or more individuals? Yes/No

If yes, do the people live in multiple states? Yes/No

Number of individuals affected by the breach:  
\_\_\_\_\_

Names of individuals affected by the breach: (attach list)

The types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code):  
\_\_\_\_\_

Description of what Business Associate is doing to investigate the breach, to mitigate losses, and to protect against any further breaches:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact information to ask questions or learn additional information:  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**AGREEMENT TO PAY FQHCs FOR OUT-OF-NETWORK EMERGENCY SERVICES**

**I. PAYMENT REQUIREMENTS**

- A. Effective October 1, 2010, an MCO shall reimburse an out-of-network federally qualified health center (FQHC) for services provided to an Enrollee that are immediately required due to an unforeseen illness, injury, or condition if:
  - 1. The FQHC participates in the Medical Assistance Program;
  - 2. The FQHC does not have a contract with the MCO;
  - 3. The services are immediately required due to the Enrollee’s unforeseen illness, injury, or condition;
  - 4. The emergent services are provided on site at the FQHC; and
  - 5. The FQHC has, before rendering services, verified with the Enrollee’s primary care provider that the Enrollee cannot be seen within a reasonable amount of time based on the severity of the Enrollee’s condition.
  
- B. An MCO may require that the FQHC provide documentation that the FQHC has obtained the verification required under A(5) of this agreement. An MCO is not required to reimburse an out-of-network FQHC for emergent services provided to an Enrollee if the FQHC fails to provide the documentation.
  
- C. An MCO may require that the FQHC provide documentation that services were required for the reasons identified under A(3) of this agreement. An MCO is not required to reimburse an out-of-network FQHC for emergent services provided to an Enrollee if the FQHC fails to provide the documentation.
  
- D. The rate at which the MCO shall reimburse an out-of-network FQHC for services provided under A of this agreement shall be the rate identified in COMAR 10.67.04.21.
  
- E. For any reimbursement paid by an MCO under A of this agreement, the Program shall pay the MCO the difference between the rates identified in COMAR 10.67.04.21 and COMAR 10.09.08.05-1.

Initial Here: \_\_\_\_\_ Date: \_\_\_\_\_

## MANAGED CARE ORGANIZATION REIMBURSEMENT

This agreement to establish new reimbursement rates is made this \_\_\_\_\_ day of \_\_\_\_\_, 2020, between the Maryland Department of Health (Department) and \_\_\_\_\_, a Managed Care Organization (MCO).

### I. MCO Reimbursement Rates

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) 2020 Medicaid Managed Care Rate Development Guide requires that states include a Medicaid MCO's rates into the HealthChoice Managed Care Organization Agreement, and amend the Agreement whenever the rates change in accordance with 42 CFR 438.7(c); and

WHEREAS, the Department has established new rates, as set forth in Appendix C, effective January 1, 2021.

1. MCO agrees to accept the reimbursement rates set forth in Appendix C, effective January 1, 2021.
2. The Department agrees to reimburse MCO at the rates set forth in Appendix C, effective January 1, 2021.

### II. Coronavirus Disease of 2019 Risk Corridor Reimbursement Methodology

WHEREAS, in response to the Coronavirus Disease of 2019 (Covid-19) and its impact on the economy and the Maryland Medicaid Managed Care Program, the Department has established the following risk corridor reimbursement methodology in response to Covid-19, for calendar year 2021:

1. **Structure of the Risk Corridor.** The risk corridor will be based on aggregate program-wide experience, excluding Kaiser Permanente of the Mid-Atlantic States (KPMAS), as follows:
  - a. A "Combined Ratio" shall be calculated by taking the "Total Expenses" of all the non-KPMAS MCOs and dividing it by the "Total Revenues" of all the non-KPMAS MCOs, where
    - i. "Total Revenue" is capitation revenue less reinsurance premiums, and
    - ii. "Total Expenses" include Medical expenses (less reinsurance recoveries and including incurred but not reported claims), Administrative Costs, Medical Management, Premium Tax, and Affordable Care Act (ACA) Fee expenses.

- b. Aggregate risk corridor means that the program-wide experience will be used (excluding KPMAS) to determine which corridor bands apply to MCO.
- c. The risk corridor will assume a profit margin of one-point six percent (1.6%) such that the risk corridor's optimum performance is a Combined Ratio of ninety-eight-point four percent (98.4%).
- d. The risk corridors shall be calculated based on their variance from ninety-eight-point four percent (98.4%). For example, Corridor A (see table below) shall be ninety-eight-point four percent (98.4%), plus or minus one-point six percent (1.6%), for a range of ninety-six-point eight percent (96.8%) to one hundred percent (100%). The corridors and the allocations of profit and loss are as follows:

Band Label	Risk Corridor Band	MCO Share	State/Federal Share
Corridor C+	Less than 95.29%	10%	90%
Corridor B+	95.30% - 96.79%	50%	50%
Corridor A	96.80% - 100.00%	100%	0%
Corridor B-	100.01% - 101.50%	50%	50%
Corridor C-	Greater than 101.51%	10%	90%

**2. Application of Risk Corridor to MCOs.** All MCOs shall be subject to the same risk corridors ("Band Labels" in the table above) based on the Combined Ratio. For example, if the Combined Ratio percentage is ninety-nine-point five percent (99.5%) (within Corridor A), no corridor adjustments are applied and MCOs retain their individual profits or losses. However, if the Combined Ratio were ninety-six percent (96%) (within Corridor B+), an individual MCO's profits greater than three-point two percent (3.2%) will be allocated fifty percent (50%) to the MCO and fifty percent (50%) to State and Federal governments (per table above). The allocations of each MCO's profits or losses, either to the MCO or to the State and Federal Government, shall depend on (1) the corridor into which the Combined Ratio falls, which determines the risk corridor bands that can apply to an MCO's profits or losses, and (2) the risk corridor in which that portion of the MCO's profit or loss percentage falls:

- a. For Corridor A, the MCO shall be allocated one hundred percent (100%) of the first three-point two percent (3.2%) of profits.
- b. For Corridor B+, profits after three-point two percent (3.2%) to four-point seven percent (4.7%) shall be allocated fifty percent (50%) to the MCO (50%) and fifty percent (50%) to the State and Federal Government. For Corridor B-, the initial one-point five percent (1.5%) of revenue losses shall be allocated



fifty percent (50%) to the MCO and fifty percent (50%) to the State and Federal Government.

- c. For Corridor C+, profits over four-point seven percent (4.7%) of revenue shall be allocated ten percent (10%) to the MCO and ninety percent (90%) to the State and Federal Government. For Corridor C-, revenue losses exceeding one-point five percent (1.5%) shall be allocated ten percent (10%) to the MCO and the ninety percent (90%) to the State and Federal Government.

3. The Department will make the eighty-five percent (85%) MLR calculation, pursuant to Section II.K of the 2021 HealthChoice Managed Care Organization Agreement, after performing the above aggregate risk corridor calculations. The eighty-five percent (85%) MLR will account for any profits or losses allocated as a result of application of the risk corridor reimbursement methodology.

4. MCO agrees to accept the risk corridor reimbursement methodology set forth in this Appendix C, effective January 1, 2021.

5. The Department agrees to reimburse the MCO in accordance with the risk corridor reimbursement methodology set forth in this Appendix C-1, effective January 1, 2021.

**[INSERT RATE TABLE]**

IN WITNESS WHEREOF, the parties hereto have hereunder executed this Appendix the day and year first above written.

FOR THE DEPARTMENT:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tricia Roddy, Assistant Medicaid Director  
Office of Health Care Financing  
Maryland Department of Health

FOR THE MCO:

\_\_\_\_\_  
Date


\_\_\_\_\_  
Signature

\_\_\_\_\_

\_\_\_\_\_

**MEMORANDUM**

**To:** HealthChoice Managed Care Organizations

**From:** Shannon McMahon   
Deputy Secretary, Health Care Financing

**Date:** November 5, 2015

**Re:** MCO Performance Monitoring Updates

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Thank you for your comments on the MCO Performance Monitoring Policies that were originally distributed in 2012. The final Performance Monitoring Policies will take effect in Calendar Year 2016. After consideration of your comments, the following changes were made:

- New Performance Monitoring elements. The Department has added the EPSDT/Healthy Kids Review to replace the PCP Satisfaction Survey and Required Reports Compliance elements from 2012.
- Removed the Consumer Report Card as a Performance Monitoring element.
- Added more detail around enforcement options.
- New Systems Performance Review cycle.
- Deemed 9 SPR elements and 13 SPR individual components.

The Department thanks the four MCOs that submitted comments on policy revisions.

The Performance Monitoring Policies will also be shared at the Quality Assurance Liaison Committee meeting on December 10, 2015.

cc: Jill Spector  
Rosemary Murphey  
Glendora Finch

## **HEALTHCHOICE MCO PERFORMANCE MONITORING POLICIES**

The Department may choose any of the performance enforcement options described, depending on the severity and persistence of the issue. The Department is not required to use the enforcement tools sequentially as a form of “progressive discipline.” Rather, the Department may use its judgment and discretion, as the oversight agency with fiduciary responsibilities, to utilize the appropriate enforcement tool for the situation.

The Department reserves flexibility in the process and timing for rescinding penalties.

### **Network Adequacy**

COMAR 10.67.05 sets forth network requirements for MCOs. The Department can act when MCOs are not in compliance with 10.67.05 and/or when a provider or recipient submits a complaint.

### **HEDIS Measures**

The Department will send MCOs an annual HEDIS announcement letter containing the specific measures/elements for the coming year. Baseline measures will not be reviewed as part of performance monitoring. Low HEDIS scores could result in a consumer report card star rating change or a financial disincentive in the Value Based Purchasing (VBP) Initiative.

### **EPSDT/Healthy Kids Review**

This is a new performance monitoring element. The minimum compliance score for each area is 80%. An assessment is performed for each MCO in each of the following EPSDT components: Health and Developmental History, Comprehensive Physical Examination, Laboratory Tests/At-Risk Screenings, Immunizations, and Health Education and Anticipatory Guidance.

### **Systems Performance Review**

To relieve administrative burdens on MCOs, the Department is switching to administering full SPRs for each MCO on a three-year cycle, beginning in SPR Reporting Year 2016 (Review Year CY 2015). On an annual basis, in order to assess MCO CAP implementation, auditors will only review elements or components which received a “partially met” or “unmet.” MCOs failing to fully implement CAPs for multiple, consecutive years will receive full reviews on an annual basis until reaching 100% on all standards.

**Part 1. Enforcement Guidelines – Minor Problems**

	<b>MCO Network Adequacy</b>	<b>HEDIS Performance</b>	<b>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/ Healthy Kids Review</b>	<b>Systems Performance Review (SPR)</b>
<b>Examples of Minor Problems</b>	Minor provider or recipient complaint.	<ul style="list-style-type: none"> <li>- One year with 30% or more elements with scores below the National Medicaid HEDIS Mean (NHM).</li> <li>- Two consecutive years with 30% or more elements with scores below the NHM.</li> </ul>	Receives less than 80% in one or more components for a review year.	Does not receive a “Met” in an element or component.
<b>Enforcement</b>	<ul style="list-style-type: none"> <li>- Verbal request for clarification.</li> <li>- Corrective Action Plan (CAP) to prevent future a network adequacy problem.</li> <li>- Geo-Access Report.</li> </ul>	Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options.	Written CAP within 45 days of presentation of preliminary report.	<ul style="list-style-type: none"> <li>- Written CAP within 45 days of presentation of preliminary report.</li> <li>- Focused EQRO audit of specific elements/components on an annual basis.</li> </ul>

**Part 2. Enforcement Guidelines – Moderate Problems**

	<b>MCO Network Adequacy</b>	<b>HEDIS Performance</b>	<b>EPSDT/Healthy Kids Review</b>	<b>SPR</b>
<b>Examples of Moderate Problems</b>	Persistent minor provider or recipient complaints PCP to recipient ratio appears inadequate but recipients are still able to access a PCP.	Three years in a row or three years within a five-year period with 30% or more elements with scores below the NHM.	Receives less than 80% in one or more components for two review years -- this score could be for the same component or different components.	Receives an “Unmet” score two years in a row on the same element (without components) or an “unmet” or “partially met” score on the same component.
<b>Enforcement</b>	<ul style="list-style-type: none"> <li>- Written CAP within 30 days of finding.</li> <li>- Geo-Access Report.</li> <li>- Financial sanctions.</li> <li>- Required to pay for out-of-network care and transportation.</li> </ul>	<ul style="list-style-type: none"> <li>- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options.</li> <li>- Freeze auto assignments in areas of the state as determined by the Department.</li> </ul>	<ul style="list-style-type: none"> <li>- Written CAP within 45 days of presentation of preliminary report.</li> <li>- Focused provider education project of specific component for two calendar years.</li> </ul>	<ul style="list-style-type: none"> <li>- Second Partially Met score on component will be changed to an Unmet score.</li> <li>- Written CAP within 45 days of presentation of preliminary report.</li> <li>- Focused EQRO audit of specific elements or components on an annual basis.</li> <li>- Monitoring of CAP by EQRO on quarterly basis, with failure to implement linked to freezing auto-assignments, freezing voluntary assignments, or financial sanctions.</li> </ul>

**Part 3. Enforcement Guidelines – Major Problems**

	<b>MCO Network Adequacy</b>	<b>HEDIS Performance</b>	<b>EPSDT/Healthy Kids Review</b>	<b>SPR</b>
<b>Examples of Major Problems</b>	<ul style="list-style-type: none"> <li>- Persistent PCP to recipient ratio appears inadequate (greater than 1:500) but recipients are still able to access a PCP.</li> <li>- No access to OB/GYN and/or no choice of PCP.</li> </ul>	<ul style="list-style-type: none"> <li>- Four years in a row or four years within a five-year period with 30% or more elements with scores below the NHM.</li> <li>- Four years in a row or four years within a five-year period with any of the HEDIS VBP measures with scores below the NHM.</li> </ul>	Receives less than 80% in one or more components for three consecutive years, or for three years within a five-year period – this score could be for the same component or different components.	Receives an “Unmet” score three or more years in a row on the same element (without components) or an “unmet” or “partially met” score on the same component.
<b>Enforcement</b>	<ul style="list-style-type: none"> <li>- CAP within 10 days of finding.</li> <li>- Geo Access Report.</li> <li>- Financial Sanction.</li> <li>- Required to pay for out-of-network care and transportation.</li> <li>- Allow recipients in problem service area(s) to voluntarily disenroll from MCO immediately.</li> <li>- Freeze auto assignments in problem service area(s).</li> <li>- Freeze voluntary</li> </ul>	<ul style="list-style-type: none"> <li>- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options.</li> <li>- Freeze auto assignments in areas of the state as determined by the Department.</li> <li>- Freeze voluntary enrollment in areas</li> </ul>	<ul style="list-style-type: none"> <li>- Written CAP within 45 days of presentation of preliminary report.</li> <li>- Monitoring of CAP by EQRO on quarterly basis, with failure to implement linked to freezing auto-assignments or financial sanctions.</li> <li>- Focused provider education project of specific component for three calendar years.</li> <li>- Freeze auto assignments in</li> </ul>	<ul style="list-style-type: none"> <li>- Second Partially Met score on component will be changed to an Unmet score.</li> <li>- Written CAP within 45 days of presentation of preliminary report.</li> <li>- Focused EQRO audit of specific elements or components on an annual basis.</li> <li>- Monitoring of CAP by EQRO on quarterly basis, with failure to</li> </ul>



	<p>enrollment in problem service area(s).</p> <ul style="list-style-type: none"> <li>- Freeze the MCO to all future enrollment in problem service area(s) (moving current recipients into another MCO of their choice).</li> <li>- Additional financial sanctions beyond paying for out-of-network care and transportation.</li> <li>- Contract termination/MCO closure in all affected counties.</li> </ul>	<p>of the state as determined by the Department.</p> <ul style="list-style-type: none"> <li>- Financial sanctions other than enrollment freeze.</li> <li>- Contract termination and MCO closure in all counties.</li> </ul>	<p>areas of the state determined by the Department.</p>	<p>implement linked to freezing auto-assignments, freezing voluntary assignments, or financial sanctions.</p> <ul style="list-style-type: none"> <li>- MCO will be subject to full SPR review annually.</li> </ul>
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**MANAGED CARE ORGANIZATION SERVICE AREA PARTICIPATION,  
OPTIONAL SERVICES AND BENEFITS, AND IN-LIEU-OF SERVICES AND  
SETTINGS**

This agreement to designate Service Area Participation, Optional Services or Benefits, and In-Lieu-Of Services or Settings is made this \_\_\_\_\_ day of \_\_\_\_\_, 2020, between the Maryland Department of Health (Department) and \_\_\_\_\_, a Managed Care Organization (MCO).

A. Definitions.

All terms capitalized herein shall have the same meaning as those in the HealthChoice Managed Care Organization agreement, except that the following terms shall have the meanings stated:

1. "Participation" means the arrangement under which the MCO arranges for and/or provides services to Enrollees in approved Service Areas, subject to applicable provisions of federal law, the Maryland Code, COMAR, transmittals, and guidelines issued by the Department in effect at any time during the term of this Agreement. "Participation" includes the MCO's enrollment of Medicaid recipients who have selected the MCO and those auto-assigned by the Department.
2. "Service Areas" means the 23 counties and Baltimore City that comprise the State of Maryland.
3. "Open" means any Service Area that the MCO has participated in during the previous calendar year.
4. "Closed" means any Service Area in which the MCO has never participated.
5. "Involuntarily Frozen" means any Service Area in which the Department freezes the auto-assignment of enrollees in a Service Area, for reasons including, but not limited to, insufficient provider networks and imposition of sanctions.
6. "Voluntarily Frozen" means any Service Area in which the MCO requests freezing the auto-assignment of enrollees. Being "Voluntarily Frozen" remains in effect for two calendar years.
7. "Request to Open" means a request by the MCO to Open any Service Area that was previously Closed, Voluntarily Frozen, or Involuntarily Frozen, pending review and approval by the Department.
8. "In-Lieu-Of Service or Setting" means a medically appropriate, cost-effective substitute for a covered service or setting under the State Plan. An Enrollee is not required to use the alternative service or setting.

9. “Optional Service or Benefit” means any service that the MCO voluntarily agrees to provide whose cost is not included in the capitation rates determined in Appendix C or future iterations of this Agreement.

B. The MCO agrees:

1. To express its intent to Open, Request to Open, or request to be Voluntarily Frozen in a Service Area during the term of this Agreement, effective January 1, 2021, as identified in this Appendix in accordance with 42 CFR 438.207;
2. That a Request to Open and a request to be Voluntarily Frozen are subject to review and approval by the Department before they become effective;
3. That the Department’s approval of a request to be Voluntarily Frozen in a Service Area does not stay any obligation under this Agreement to accept and serve Enrollees who select the MCO;
4. To provide the Optional Services or Benefits and In-Lieu-Of Services and Setting during the term of this Agreement, effective January 1, 2021, as identified in this Appendix in accordance with 42 CFR 438.3(e);

C. The Department and the MCO agree:

1. That the costs of any Optional Services or Benefits shall not be included when determining the capitation rates identified in Appendix C of this Agreement or future capitation rate calculations;
2. That the utilization and actual cost of In-Lieu-Of Services or Settings shall be taken into account in developing the component of future capitation rates that represents the covered State Plan services, unless a statute of regulation explicitly requires otherwise; and
3. That the provision of services identified in this Appendix is subject to approval of this Agreement by the Centers for Medicare and Medicaid Services.

**MCO SERVICE AREA PARTICIPATION**

<b>Service Area</b>	<b>Current Participation Status</b>	<b>No Change</b>	<b>Request to Open</b>	<b>Voluntary Enrollment Freeze</b>
<b>Allegany</b>				
<b>Anne Arundel</b>				
<b>Baltimore City</b>				
<b>Baltimore County</b>				
<b>Calvert</b>				
<b>Caroline</b>				
<b>Carroll</b>				
<b>Cecil</b>				
<b>Charles</b>				
<b>Dorchester</b>				
<b>Frederick</b>				
<b>Garrett</b>				
<b>Harford</b>				
<b>Howard</b>				
<b>Kent</b>				
<b>Montgomery</b>				
<b>Prince George's</b>				
<b>Queen Anne's</b>				
<b>St. Mary's</b>				
<b>Somerset</b>				
<b>Talbot</b>				
<b>Washington</b>				
<b>Wicomico</b>				
<b>Worcester</b>				

**OPTIONAL BENEFITS OFFERED BY THE MCO**


**IN-LIEU-OF SERVICES PROVIDED BY THE MCO**

The Department has determined the following alternative services or settings are medically appropriate and cost-effective substitutes for the covered services or settings identified in the State Plan:


IN WITNESS WHEREOF, the parties hereto have hereunder executed this Appendix the day and year first above written.

FOR THE DEPARTMENT:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tricia Roddy, Assistant Medicaid Director  
Office of Health Care Financing  
Maryland Department of Health

FOR THE MCO:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_

\_\_\_\_\_

## NETWORK ADEQUACY 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 must meet either the time or distance standard for each county in the MCO's service area.

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

### ADDITIONAL NETWORK REQUIREMENTS

HealthChoice MCOs must meet all network requirements set forth in COMAR 10.67.05, including:

<sup>1</sup> Urban Counties: Baltimore City

<sup>2</sup> Suburban Counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, Prince George's

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

<sup>4</sup> 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.

1. Offering an appropriate range of preventive, primary care, and specialty services adequate for the anticipated number of Enrollees in the MCO's service areas.
2. Maintaining a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the number of Enrollees in the MCO's service areas.
3. Ensuring that in-plan individual practitioners, based on full-time equivalency, are assigned no more than the number of enrollees that is consistent with a 200:1 ratio of enrollee to practitioner in the local access area.
4. Maintaining written policies and procedures for selecting and retaining network providers in accordance with the requirements of 42 CFR 438.214 and the applicable provider panel provisions of Maryland Insurance Article § 15-112, Code Ann.
5. Ensuring that all network providers are screened, enrolled, and revalidated by the State as Medicaid providers, in accordance with 42 CFR part 455, subparts B and E, and validate enrollment by verifying against the Department's full fee-for-service provider file.
6. Accepting the Maryland Uniform Credentialing Form for the credentialing of network providers.
7. Refraining from discriminating against providers serving high-risk populations or specializing in conditions requiring costly treatment.
8. Informing all providers at the time of entering into a contract with the MCO about the grievance and appeal system, as set forth in 42 CFR 438.414 and 42 CFR 438.10(g)(2)(xi).
9. Monitoring the Department's correspondence and any database publicizing Department-initiated terminations of providers from the Program.
10. Terminating the contract of, or refraining from contracting with, providers terminated or excluded from participating in the Program.
11. Developing and distribute a provider manual that includes all of the information provided in the Department's template and required in COMAR 10.67.05.04A(2).
12. Ensuring 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.
13. Ensuring its provider network can provide physical access, reasonable accommodation, and accessible equipment for Enrollees with physical or mental disabilities.
14. Providing necessary services covered under the contract out of network adequately and timely for a particular Enrollee, for as long as the MCO's provider network is unable to provide them.

## **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 its 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.

If an MCO can otherwise demonstrate to the Department's satisfaction the adequacy of its provider network notwithstanding its inability to meet these requirements, the Department may, in its discretion, approve the network if special circumstances exist which, considered along with the overall strength of the MCO's network, establish that the Department's approval of the network will enhance recipients' overall access to quality health care services in the area to be served.

**CMS Medical Loss Ratio (MLR) Standards**  
CY 2020

MCO Name:

MCO Provider Number(s):

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INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION  
CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR  
IMPRISONMENT UNDER FEDERAL LAW

**CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF MCO**

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying information prepared by \_\_\_\_\_ (MCO name) for the CMS MLR reporting period beginning \_\_\_\_\_ and ending \_\_\_\_\_, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the MCO in accordance with 42 CFR §438.8, except as noted.

\_\_\_\_\_  
(Signed)

Chief Financial Officer or Administrator of MCO(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Telephone Number of Person to Contact for More Information

## **Instructions for completion of Medical Loss Ratio (MLR) Reporting Template 42 CFR §438.8 - Medical Loss Ratio (MLR) standards**

States must require that MCOs calculate and report an MLR for the rating period that begins in 2020

### **Worksheet 2 (Reporting Template)**

**Line 1: MCO Reporting: Name of MCO**

**Line 2: Incurred Period: Period (calendar year) services were incurred**

**Line 3: Report date: As of June 30th following the incurred period**

**Line 4: Contact Name: MCO contact name**

**Line 5: Phone Number of MCO contact**

**Line 6: e-mail address of MCO contact**

**Line 7: Due date of submission to MDH: September 30th following the incurred period**

**Line 8: MLR Calculation - Please complete lines i. through vi. And line xi (lines viii. - x. are calculated cells)**

### **Worksheet 3 (Credibility Table) - Table developed by CMS Office of the Actuary**

The calculation illustrated in cell C17 is for annual member months between 48,000 or 96,000.

Please modify cell C17 to reflect the range of your annual member months.

MCOs with annual member months greater than 380,000 would have a credibility adjustment of zero.

**Attestation MLR form - In addition to submission of this Excel file, please complete the Word version of the attached attestation document.**

**In addition to completing this file and separate attestation document, please provide the following:**

- 1. Include a separate audited financial underwriting exhibit reflecting HealthChoice only experience for the current reporting year.**
- 2. Provide documentation (as needed) supporting the methodology used to allocate expenses under multiple expense categories as stated on the reporting template in worksheet 2.**

**MARYLAND HEALTHCHOICE ONLY PRODUCT LINE**

- 1. MCO Reporting: **MCO A**
- 2. Incurred Period: **January 1, 2020 - December 31, 2020**
- 3. Reported as of: **June 30, 2021**
- 4. Contact Person: **Jane Doe**
- 5. Phone Number: **xxx-xxx-xxxx**
- 6. E-mail Address: **abc@def.com**
- 7. Report due to MDH: **November 15, 2021**
- 8. MLR Calculation:

(Aggregate for all Medicaid Eligibility Groups)

(Sample Calculation)

(Notes)

Reporting Components:

(i.a) Total incurred claims.	<u>\$ 47,400,000</u>
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	<b>(i.b) PBM Spread (admin &amp; profit) reported in i.a.</b>	<u>\$ -</u>
	<b>(i.c.) Total net incurred claims (i.a – i.b)</b>	<u>\$ 47,400,000</u>
<b>42 CFR §438.8(e)(3)</b>	<b>(ii) Expenditures on quality improving activities.</b>	<u>\$ 900,000</u>
<b>(Program Integrity Requirements)</b>	<b>(iii) Expenditures related to activities compliant with 42 CFR §438.608(a)(1) through (5), (7), (8) and (b).</b>	<u>\$ 150,000</u>
	<b>(iv) Non-claims costs.</b>	<u>\$ 6,450,000</u>
	<b>(v) Premium revenue.</b>	<u>\$ 60,000,000</u>
<b>Split between Prem &amp; Inc. Tax</b>	<b>(vi) Taxes, licensing and regulatory fees.</b>	<u>\$ 1,840,000</u>
	<b>(vii) Methodology(ies) for allocation of expenditures.</b>	<u>See instructions worksheet</u>
	<b>(ix) Any credibility adjustment applied.</b>	<u>2.40%</u>
	<b>(x) The calculated MLR (after credibility adjustment)</b>	<u>85.4%</u>
	<b>(xi) Any remittance owed to the State, if applicable.</b>	<u>\$ -</u>
	<b>(xii) Member Months</b>	<u>75,000</u>

**Credibility Table for Medicaid and CHP Managed Care Plans effective for services incurred January 1, 2017\***

<u>Reporting Year Member Months</u>	<u>Credibility Adjustment</u>
< 5,400	Non-credible
5,400	8.40%
12,000	5.70%
24,000	4.00%
48,000	2.90%
96,000	2.00%
192,000	1.50%
380,000	1.00%
>380,000	Fully Credible

\*Adjustment applied rounded to the nearest tenth using linear interpolation.

Same table (developed by CMS Office of the Actuary) as provided in last year's template

**Member Months**

**75,000**

**Calculated Adjustment**

**2.40%**

**(Note: as needed, please adjust formula to reflect your actual member months)**

## **MATERNAL OPIOID MISUSE (MOM) MODEL AGREEMENT**

This agreement to participate in the Center for Medicare and Medicaid Innovation-funded (CMMI) Maternal Opioid Misuse Grant (MOM Grant), contingent upon continued funding by CMMI, is made this \_\_\_\_\_ day of \_\_\_\_\_, 2020, between the Maryland Department of Health (Department) and \_\_\_\_\_, a Managed Care Organization (MCO).

MCO Legal Name:

MCO Tax Identification Number:

MCO National Provider Identification Number:

A. In the Pre-Implementation Period of Model Year 2 of the MOM Grant (January 1, 2021 – June 30, 2021), the Department agrees to:

1. Comply with all requirements of the MOM model grant as outlined by CMMI, including the obligations included in the MOM Model funding.
2. Contract with the MCO, including continued execution of the Data Use Agreement (DUA) annually. Ensure provision of usable claims and encounter data needed to operate and evaluate the MOM Model when amending the DUA.
3. Coordinate with the MCO in support of information-sharing, to the extent permitted by law and under the DUA.
4. Collaborate with the MCO to design and plan for the implementation of a MOM model intervention that coordinates and delivers physical and behavioral healthcare services, along with appropriate care management and coordination, beneficiary engagement, and referrals to community or other support services for the MOM model population.
5. Support the development and sustainability strategies of the MCO to increase provider capacity, establish data-reporting infrastructure, strengthen collaborative relationships among providers, leverage telemedicine and other resources, and continue appropriate investments in service-delivery transformation.
6. Designate a point of contact for data collection and reporting to ensure accurate and timely reporting of claims and utilization data to CMS; serve as a liaison between CMMI, MOM Model participants and other partners; facilitate communication, addressing and ameliorating difficulties; and ensure the Department's data reporting comports with the CMMI requirements.

B. In the Pre-Implementation Period of Model Year 2 of the MOM Grant (January 1, 2021 – June 30, 2021), the MCO agrees to:

1. Confirm that they are in compliance with Medicaid Program integrity rules at 42 CFR Part 455.
2. Execute a contract and data sharing agreement with the Department.
3. Acquire or build needed resources and prepare to operationalize the MOM care delivery model.
4. Strengthen its capacity and that of its provider network to administer, deliver and evaluate the MOM intervention program in a collaborative manner.

5. Establish data-reporting infrastructure and associated information-sharing systems and processes; participate in training and testing activities for grant-related reporting mechanisms.
  6. Actively support the Department to achieve monitoring requirements, and operational/performance milestones.
  7. Report required data to the Department and CMMI, in accordance with the aforementioned Notice of Funding Opportunity and the terms of the contract and data sharing agreement.
  8. Participate in all planning and implementation calls, site visits, observations, interviews and focus groups required either by the Department and/or the program implementation, learning system and evaluation contractors working for CMMI in support of the MOM model intervention and evaluation.
- C. In the Transition Period of Model Year 2 of the MOM Grant (July 2021 – December 2021), the Department agrees to:
1. Comply with all requirements of the MOM model grant as outlined by CMMI, including the obligations included in the MOM model funding.
  2. Contract with the MCO, including continued execution of the Data Use Agreement (DUA) annually. Ensure provision of usable claims and encounter data needed to operate and evaluate the MOM Model when amending the DUA.
  3. Coordinate with the MCO in support of information-sharing, to the extent permitted by law and under the DUA.
  4. In accordance with MOM model quarterly reporting, provide per member, per month reimbursement to MCOs for provision of MOM model services in accordance with Subpart D, subject to retroactive review and approval by CMMI to receive MOM model transition funding.
- D. In the Transition Period of Model Year 2 of the MOM Grant (July 2021 – December 2021), the MCO agrees to:
1. Confirm that they are in compliance with Medicaid Program integrity rules at 42 CFR Part 455.
  2. In accordance with MOM model quarterly reporting, to receive the per member, per month reimbursement of \$208 in accordance with Subpart C, provide the following services, at a minimum, on a monthly basis to MOM model participants:
    - a. Ensure MOM model participants access at least one physical or behavioral health care services billable to Medicaid, including:
      - i. Physical health care: Maternity care and relevant primary care services; and
      - ii. Behavioral health care: Medication-assisted treatment (MAT) for opioid use disorder (OUD), mental health and other appropriate substance use services beyond MAT.
    - b. Coordinate care, engage participants and provide referrals for community and other support services to complement the current set of Medicaid-covered services to meet MOM model participants' comprehensive needs, including screening and



referral for health-related social needs, measurement of patient activation and to satisfy at least one of the following model components per month:

- i. Comprehensive care management;
  - ii. Care coordination;
  - iii. Health promotion;
  - iv. Individual and family support; and
  - v. Referral to community/support services.
3. In accordance with MOM model quarterly reporting, to receive the per member, per month reimbursement of \$207 in accordance with Subpart C, conduct substantive outreach for MOM model participants who are disengaged from care, i.e., who have not received a physical or behavioral health care service during a given calendar month, for up to two consecutive months per MOM model participant.
  4. Support the reporting of required data to CMMI, (though the MOM Care Coordination Module, claims and encounter data and other modalities as identified) and accordance with award, including:
    - a. Beneficiary monitoring data
      - i. Number of newly-enrolled MOM model participants;
      - ii. Number of MOM model participants continuing in care; and
      - iii. Number of disengaged MOM model participants;
    - b. Performance milestones
      - i. Continuity of pharmacotherapy at delivery;
      - ii. Gains in Patient Activation Measurement® scores;
      - iii. Health-related social needs screening completion;
      - iv. Maternal engagement in opioid use disorder treatment; and
      - v. Postpartum care and family planning;
    - c. Monitoring measures
      - i. Depression screening and follow-up; and
      - ii. Tobacco screening and cessation intervention.

#### E. Corrective Action

1. General. MCO shall comply with the MOM model responsibilities as set forth in this contractual agreement.
2. Notification of Issues. MCO shall notify the Department's MOM model Authorized Official Representative (AOR) and Project Director within 10 business days of any significant problems or risks related to the administrative, financial or programmatic aspects of the award during the performance period of this contractual agreement. Significant problems or risks include any event, issue or circumstance that could prevent the MCO from timely achieving any of the responsibilities identified in this contractual or otherwise negatively impact the ability of MCO to implement the MOM model.

MOM Model AOR:

Tricia Roddy

Phone: 410-767-5609

Email: [tricia.rodde@maryland.gov](mailto:tricia.rodde@maryland.gov)

MOM Model Project Director:      Laura Goodman  
Phone: 410-767-5683  
Email: laura.goodman@maryland.gov

- 3. Corrective Action. The Department may in its sole discretion elect to permit the MCO to take appropriate corrective action to remedy an issue that has placed the MCO at risk of non-compliance with this contract or if the Department determines that the MCO is out of compliance with the contractual requirements. Corrective action is not available to address an action or deficiency that endangers public welfare.
  
- F. The terms and conditions of this Appendix are contingent upon the availability of MOM Grant funding. Any delays or extensions to the MOM Grant by CMMI will result in an amendment to this Appendix.

IN WITNESS WHEREOF, the parties hereto have hereunder executed this Appendix the day and year first above written.

FOR THE DEPARTMENT:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tricia Roddy, Assistant Medicaid Director  
Office of Health Care Financing  
Maryland Department of Health

FOR THE MCO:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature  
  
\_\_\_\_\_

## **HEALTHCHOICE FINANCIAL SANCTION POLICY**

This policy outlines financial sanctions that the Maryland Department of Health (MDH) may levy on Managed Care Organizations (MCOs). It does not address other sanctions available under COMAR 10.67.10 which may be used in addition to or instead of the financial sanctions described in this policy.

MDH may impose any of the financial sanctions described, depending on the severity and persistence of the issue. MDH is not required to use the sanctions sequentially as a form of “progressive discipline.” Rather, MDH may use its judgment and discretion, as the oversight agency with fiduciary responsibilities, to utilize the appropriate sanction for the situation. MDH reserves flexibility in the process and timing for rescinding sanctions.

### **DEFINITIONS**

**Corrective Action Plan:** A written, detailed plan to address non-conformity with a law, regulation, contract term, policy, or deadline.

**Deficiency:** A failure to comply with any applicable law, regulation, contract term, policy, or deadline established by MDH or its designees. Each failure to comply is a separate deficiency.

### **FINANCIAL SANCTION GUIDELINES**

1. MDH may impose any of the financial sanctions described below.
2. MDH shall notify an MCO of a deficiency in writing to explain the basis and nature of the deficiency, as well as any sanctions MDH will impose.
3. For any deficiency, MDH may impose a sanction of up to \$1,000,000 multiplied by the MCO’s market share percentage at the beginning of the term of the Agreement in effect.
  - a. The notice may include an opportunity for the MCO to submit a plan to take corrective action. The corrective action plan (CAP) will be subject to the review and approval of MDH.
  - b. Should the MCO submit and implement a CAP and it fails to remedy the identified deficiencies, MDH may impose the following financial sanctions, in addition to any sanctions initially imposed for the deficiency:
    - i. One failure to implement: up to \$100,000 multiplied by the MCO’s market share percentage;
    - ii. Two failures to implement: up to \$500,000 multiplied by the MCO’s market share percentage; and

- iii. Three or more failures to implement: up to \$1,000,000 multiplied by the MCO's market share percentage.

*Example: At the start of CY 2021, MCO A has a 20% market share of the HealthChoice program. MCO A is deficient in the first quarter because it has not complied with the MDH's timing requirements for enrollee appeals. MDH issues notice of the deficiency, imposes a financial sanction of \$25,000 times the market share percentage (resulting in a \$5,000 fine), and requires MCO A to submit a CAP that is reviewed quarterly. MCO A then fails to implement the CAP, and the Department issues another sanction of up to \$20,000. MCO A's second failure to implement the CAP results in a sanction up to \$100,000, and three or more failures to implement the CAP results in a sanction up to \$200,000.*

4. If the deficiency involves a failure to submit a report or CAP, submission of an inaccurate or incomplete report or CAP, or a failure to provide other information requested by MDH or its designee, MDH may impose a sanction of \$250 for each calendar day the information has not been submitted or is late, inaccurate or incomplete.
  - a. An MCO may request an extension and guidance up to 24 hours prior to the deadline for submission, which MDH may approve or deny.
  - b. The sanction will be applied at 5:00 PM on each day the information is not submitted, inaccurate, or incomplete.
  - c. MDH may double the total sanction assessed for each 14-day period that the information has not been submitted or is late, inaccurate, or incomplete.
5. Any financial sanctions described in this policy or implemented under this policy shall not preclude or otherwise impact MDH's pursuit and recovery of actual damages incurred by MDH resulting from the MCO's deficiencies related to its duties and obligations as an MCO in the HealthChoice program.
6. Financial sanctions will be deducted from the MCO's capitation payment and deposited in the HealthChoice Performance Incentive Fund, in compliance with Health-General Art. § 15-103.3.
7. This policy shall apply, at MDH's discretion, to noncompliance regardless of the timing of the noncompliant activity.

## MARYLAND QUALITY INCENTIVE PROGRAM (M-QIP) REQUIREMENTS

Contingent on CMS approval, the M-QIP Program will be implemented to improve quality outcomes, reduce ED utilization for Ambulatory Sensitive Conditions, and increase access to specialty care. The program applies to physician and certain non-physician practitioners employed by or affiliated with the University of Maryland.

- I. Eligible providers as defined below will be eligible for enhanced payments for patient care services provided. For purposes of M-QIP, an eligible provider is limited to the following provider types employed by or affiliated with the Faculty Physicians Inc. (FPI) at the University of Maryland:
  - A. Doctors of Medicine
  - B. Doctors of Osteopathy
  - C. Certified Registered Nurse Anesthetists (CRNAs)
  - D. Certified Registered Nurse Practitioners
  - E. Physician Assistants
  - F. Certified Nurse Midwives (CNMs)
  - G. Clinical Social Workers (CSWs)
  - H. Clinical Psychologists
  - I. Optometrists
  - J. Physical Therapist
  - K. Occupational Therapist
  - L. Speech Therapist
  - M. Audiologists
- II. The M-QIP program applies only to MCOs that have a contract with FPI. The MCO will not be responsible for services that they do not cover or are carved out of the HealthChoice Benefit Package.
- III. The MCO shall continue to pay their negotiated base rates to eligible providers throughout the year.
- IV. M-QIP will be funded through a separate payment term pool. The separate payment term pool will contain a set dollar amount for each contract period.
- V. MCOs contracted with FPI will receive quarterly payments from the Department. These MCOs will be required to reimburse FPI from these funds according to a schedule determined by the Department.

## HEALTHCHOICE DIABETES PREVENTION PROGRAM (DPP) FEE SCHEDULES

There are two reimbursement methodologies available to MCOs for HealthChoice DPP. **MCOs are required to pay contracted CDC-recognized type 2 diabetes prevention programs at least the minimum rates outlined in each methodology.**

Section I outlines the session and performance payment approach for reimbursing in-person and virtual CDC-recognized type 2 diabetes prevention programs. Section II outlines the milestone/bundled payment approach for reimbursing virtual CDC-recognized type 2 diabetes prevention programs only.

### Section 1: HealthChoice Session and Performance-Based Reimbursement Methodology for In-Person and Virtual DPP Providers

Participating in-person and virtual CDC-recognized type 2 diabetes prevention programs must use the make-up modifiers when submitting claims for make-up sessions using TS and VM modifiers with any code that has a session attached to it (except for the first session). In-person programs should always use the TS modifier for makeup sessions.<sup>5</sup> Virtual programs should always use the VM modifier for their makeup sessions.

HCPCS code G9891 is a code used to track attendance and indicate that the CDC-recognized type 2 diabetes prevention program furnished a session that was not accounted for using an attendance performance goal code, such as G9874 (4 core sessions attended). G9891 is a non-payable code for reporting services of sessions furnished to participants (i.e. core sessions 2-3, 5-8, and 10-16).

Table 1. *HealthChoice DPP Session-Based Reimbursement Methodology for Minimum Payment Levels for In-Person and Virtual DPP Providers*

Session/Event	HCPCS Code and Description	Payment	Modifiers			Limitation
			In-Person Make-up Session	Virtual Session <sup>6</sup>	Virtual Make-Up Session	
Session 1	G9873 <sup>7</sup> - 1st core session attended	\$100	None	GT <sup>8</sup>	None	Can be used 1 time in 365 days <sup>9</sup>
Session 2-4	G9874 - 4 total core sessions attended <sup>10</sup>	\$120	TS <sup>11</sup>	GT	VM <sup>12</sup>	Can be used 1 time in 365 days <sup>9</sup>

<sup>5</sup> In-person programs may conduct make-up sessions online, via some other virtual modality, or over the phone; these are still considered to be delivering the program in-person.

<sup>6</sup> Virtual DPP refers to online, distance learning or combination delivery modes (combination only when online and distance learning DPP services are rendered).

<sup>7</sup> CDC-recognized type 2 diabetes prevention programs must have confirmed self-referred individuals' eligibility through a blood test, or provider note indicating history of GDM, prior to billing for this code.

<sup>8</sup> The modifier GT refers to "via interactive audio and video telecommunications systems."

<sup>9</sup> In cases where MCOs allow individuals to switch DPP Providers after starting the program, the MCO may need to make an exception to the "can be used 1 time in 365 days" limitation.

<sup>10</sup> Bill with counter code G9891 two times to indicate completion of core sessions 2 and 3.

<sup>11</sup> The modifier TS refers to "follow-up service." In-person programs may only use TS to indicate a make-up session of any modality.

<sup>12</sup> The modifier VM refers to "virtual make-up session." Virtual programs may only use VM to indicate a makeup session.

						Virtual programs may only use VM to indicate make-up sessions. Do not use GT <b>and</b> VM <b>OR</b> GT <b>and</b> TS
Session 5-9	G9875 - 9 total core sessions attended <sup>13</sup>	\$140	TS	GT	VM	Can be used 1 time in 365 days <sup>9</sup>  Virtual programs may only use VM to indicate make-up sessions. Do not use GT <b>and</b> VM <b>OR</b> GT <b>and</b> TS
Session 10-19	G9876 - 2 core maintenance sessions attended in months 7-9 (weight-loss goal not achieved or maintained) <sup>14</sup>	\$40	TS	GT	VM	Can be used 1 time in 365 days <sup>9</sup>  Virtual programs may only use VM to indicate make-up sessions. Do not use GT <b>and</b> VM <b>OR</b> GT <b>and</b> TS
Session 20-22	G9877 - 2 core maintenance sessions attended in months 10-12 (weight loss goal not achieved or maintained) <sup>15</sup>	\$40	TS	GT	VM	Can be used 1 time in 365 days <sup>9</sup>  Virtual programs may only use VM to indicate make-up sessions. Do not use GT <b>and</b> VM <b>OR</b> GT <b>and</b> TS
Number of Sessions	G9891 <sup>16</sup> - MDPP session reported as a line-item on a claim for a payable MDPP service	\$0	None	GT	None	This CPT code is used to track attendance. This is a non-payable code for reporting services of sessions furnished to participants (i.e. core sessions 2-3, 5-8, and 10-16.)

**Performance Payments**

HCPCS codes G9878 and G9879 are both enhanced payments for performance: weight loss achieved or maintained for months 7-9 and 10-12. These codes may only be used in conjunction with either HCPCS code G9880 (5% weight loss) or G9881 (9% weight loss).

*Table 2. HealthChoice DPP Performance-Based Reimbursement Methodology for In-Person and Virtual DPP Providers*

Session/	HCPCS Code	Payment	Modifiers	Limitation
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<sup>13</sup> Bill with counter code G9891 four times to indicate completion of core sessions 5, 6, 7, and 8.

<sup>14</sup> Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 7-9.

<sup>15</sup> Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 10-12.

<sup>16</sup> A HCPCS G-code for a session furnished by the billing supplier that counts toward achievement of the attendance performance goal for the payable MDPP services HCPCS G-code. This CPT code is used to track attendance. This is a non-payable code for reporting services of sessions furnished to participants (i.e. core sessions 2-3, 5-8, and 10-16.)

Event	and Description		In-Person Make-up Session	Virtual Session	Virtual Make-Up Session	
5% Weight Loss	G9880 – 5 percent weight loss from baseline achieved	\$100	None	GT8	None	Can be used 1 time in 365 days <sup>9</sup>
9% Weight Loss	G9881 – 9 percent weight loss from baseline achieved	\$50	None	GT	None	Can be used 1 time in 365 days <sup>9</sup>
Session 10-19 with at least 5% weight loss	G9878 <sup>17</sup> - 2 core maintenance sessions attended in months 7-9 and weight loss goal achieved or maintained	\$80	TS11	GT	VM12	Can be used 1 time in 365 days <sup>9</sup>  Cannot be used with G9876  Virtual programs may only use VM to indicate make-up sessions. Do not use GT and VM <b>OR</b> GT and TS
Session 20-22 with at least 5% weight loss	G9879 <sup>18</sup> - 2 core maintenance sessions attended in months 10-12 and weight loss goal achieved or maintained	\$80	TS	GT	VM	Can be used 1 time in 365 days <sup>9</sup>  Cannot be used with G9877  Virtual programs may only use VM to indicate make-up sessions. Do not use GT and VM <b>OR</b> GT and TS

**Assuming the enrollee attends all sessions and all performance outcomes are met, the total payment per enrollee for the CDC-recognized type 2 diabetes prevention programs based on these rates is \$670.**

For community and/or virtual DPP providers whose organizations do not meet the descriptions provided for the place of service code set, they may use the place of service code ‘99’.<sup>19</sup>

These HCPCS codes may not be billed with or as nutritional counseling, evaluation and management codes, or other procedure codes when billing for the National DPP lifestyle change program.

<sup>17</sup> In order to bill G9878 for enhanced attendance, must also bill or have previously billed for weight loss achieved from baseline at either 5% (G9880) or 9% (G9881). Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 7-9.

<sup>18</sup> In order to bill G9879 for enhanced attendance in this period, must also bill or have previously billed for weight loss achieved from baseline at either 5% (G9880) or 9% (G9881). Bill with counter code G9891 one time to indicate completion of first of two core maintenance sessions in months 10-12.

<sup>19</sup> Place of service code ‘99’ refers to “Other place of service not identified above.” Centers for Medicare and Medicaid Services. (2016).

Place of Service Code Set: Place of Service Codes for Professional Claims. Retrieved from: [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)



## Section II: HealthChoice Milestone/Bundled Reimbursement Methodology for Virtual DPP Providers<sup>6</sup>

Table 3, below, lists the recommended HCPCS codes and reimbursement for HealthChoice DPP under the virtual DPP milestone/bundled reimbursement methodology. Flexibility in bundled payment distribution across milestones 1-3 and the 5% and 9% performance payouts will be allowed so long as the total payment per enrollee for the CDC-recognized type 2 diabetes prevention program meets or exceeds \$670.

Table 3. *HealthChoice DPP Milestone/Bundled Reimbursement Methodology for Virtual DPP Providers*

Session/Event	HCPCS Code and Description	Payment	Modifiers			Limitation
			In-Person Make-up Session	Virtual Session <sup>6</sup>	Virtual Make-Up Session	
Milestone 1: May be billed at enrollment or initiation into program; scale is issued; or 1 <sup>st</sup> core session attended	Available codes: G98736 - 1st core session attended E1639 <sup>20</sup> 0488T <sup>21</sup>	\$220	Not applicable	GT8	None	Can be used 1 time in 365 days <sup>9</sup>
Milestone 2: Billed at 4 core sessions attended	G9874 - 4 total core sessions attended	\$160	Not applicable	GT	VM12	Can be used 1 time in 365 days <sup>9</sup>  Virtual programs may only use VM to indicate make-up sessions. Do not use GT <b>and</b> VM <b>OR</b> GT <b>and</b> TS
Milestone 3: Billed at 9 core sessions attended	G9875-9 core sessions attended	\$140	Not applicable	GT	VM	Can be used 1 time in 365 days <sup>9</sup>  Virtual programs may only use VM to indicate make-up sessions. Do not use GT <b>and</b> VM <b>OR</b> GT <b>and</b> TS
Performance: 5% weight loss achieved	G9880 – 5 percent weight loss from baseline achieved	\$125	Not applicable	GT	None	Can be used 1 time in 365 days <sup>9</sup>
Performance: 9% weight loss achieved	G9881 - 9 percent weight loss from baseline achieved	\$25	Not applicable	GT	None	Can be used 1 time in 365 days <sup>9</sup>

As indicated for Milestone 1, MDH will accept one of three possible codes for enrollment or initiation into the program as a first milestone and allow claiming for the scale using either 1) G9873; 2) [E1639](#); or 3) [0488T](#).

<sup>20</sup> E1639: Durable Medical Equipment (DME)

<sup>21</sup> 0488T: Preventive behavior change, online/electronic intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days

**Assuming the enrollee attends and meets all milestones and achieves the 5% and 9% performance outcomes, total payment per enrollee for virtual CDC-recognized type 2 diabetes prevention programs based on these rates should equal \$670.**

### ICD-10 Diagnosis Codes, Descriptions and DPP Provider Assignment Guidance

The following ICD-10 diagnosis codes may be used for billing:

Table 4. *Elevated Blood Glucose Level and Gestational Diabetes ICD-10 Codes*

ICD-10 Code	Description – Elevated Blood Glucose Level	ICD-10 Code	Description - Gestational Diabetes
R73.01	Impaired fasting glucose	Z86.32 <sup>22</sup>	Personal history of gestational diabetes
R73.02	Impaired glucose tolerance - Oral	R73.03	Prediabetes

Table 5. *BMI ICD-10 Codes for BMI 23.0 and greater*

ICD-10 Code	Description – Body Mass Index	ICD-10 Code	Description – Body Mass Index
Z68.23	Body mass index (BMI) 23.0-23.9, adult	Z68.34	Body mass index (BMI) 34.0-34.9, adult
Z68.24	Body mass index (BMI) 24.0-24.9, adult	Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.25	Body mass index (BMI) 25.0-25.9, adult	Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.26	Body mass index (BMI) 26.0-26.9, adult	Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.27	Body mass index (BMI) 27.0-27.9, adult	Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.28	Body mass index (BMI) 28.0-28.9, adult	Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.29	Body mass index (BMI) 29.0-29.9, adult	Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.30	Body mass index (BMI) 30.0-30.9, adult	Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.31	Body mass index (BMI) 31.0-31.9, adult	Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.32	Body mass index (BMI) 32.0-32.9, adult	Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.33	Body mass index (BMI) 33.0-33.9, adult	Z68.45	Body mass index (BMI) ≥ 70, adult

<sup>22</sup> DPP providers should include Z86.32 as primary code for all individuals indicating history of gestational diabetes after confirming not currently pregnant.

## HIGH COST LOW VOLUME DRUG RISK MITIGATION POLICY

Maryland's Department of Health (the Department) has instituted a risk mitigation policy effective January 1, 2021 to protect the HealthChoice program from utilization fluctuations related to very high cost drugs. The policy covers both Physician Administered Drugs and retail pharmacy drugs that have an expected annual cost over \$400,000. The specific drugs covered are listed in Exhibit I of this document. The list of drugs is subject to change during the year if a new drug received FDA approval and is a covered Medicaid service with an expected annual cost over \$400,000. No previously approved and covered drugs will be added to the list during the year. If a new drug is approved and reaches the market after this analysis is complete, the Department will evaluate the expected cost of the drug and will add it to the list if the expected annual cost is over \$400,000. The list of covered drugs will be reviewed annually to add in drugs that have increased in price or remove drugs that have decreased in price.

Under this new mitigation policy, costs of the High Cost Low Volume drugs listed in Exhibit I are removed from the rate setting base data and are not included in the standard capitation rate paid to HealthChoice Managed Care Organizations (MCOs). The MCOs are still responsible for authorizing, managing, and paying all claims related to the high cost drugs, and will invoice the Department for any incurred expenses on a quarterly basis. The MCOs are expected to develop and adhere to medical necessity criteria to ensure that all instances of utilization of drugs listed in Exhibit I follow best clinical practices. The Department reserves the right to audit medical necessity criteria and review the utilization of all High Cost Low Volume Drugs to ensure adherence to appropriate criteria.

*Exhibit I – List of NDCs and J-Codes Covered by High Cost Low Volume Risk Mitigation Policy*

<b>Drug Name</b>	<b>NDC Code</b>	<b>J Code (if applicable)</b>
Actimmune	75987011111	
Actimmune	42238011112	
Cinryze	42227008105	J0598
Novoseven	00169720101	
Orfadin	66658020490	J8499
Ravicti	75987005006	
Revcovi	57665000201	J3590, J3490
Soliris	25682000101	J1300
Vimizim	68135010001	J1322
Spinraza	64406005801	J2326
Zolgensma	see list below *	J3590

\*Zolgensma NDC List: 71894011001, 71894011501, 71894012002, 71894012103, 71894012203, 71894012303, 71894012404, 71894012504, 71894012604, 71894012705, 71894012805, 71894012905, 71894013006, 71894013106, 71894013307, 71894013407, 71894013507, 71894013608, 71894013708, 71894013808, 71894013909, 71894014009, 71894014109

**HEPATITIS C RISK POOL REIMBURSEMENT METHOD**

The Department has also instituted a new method for paying for Hepatitis C treatments in the capitation rates while controlling for differences in treatment volume across MCOs. The new method eliminates the previous Hepatitis C case rate and instead funds Hepatitis C by including the expenses in the capitation rating cohorts. After the contract period has ended, the Hepatitis C prescriptions provided by MCO will be compared to the amount funded via the capitation rates, and a risk pool will be calculated to protect MCOs from adverse selection. The key aspects of the risk pool are:

1. The risk pool will not be budget neutral, meaning that MDH will add/remove dollars to the initial Hepatitis C funding provided via the capitation rates
2. The cost per prescription used in developing the capitation rates will be adjusted via a risk corridor based on the actual cost per prescription for the Medicaid program
  - a. Risk corridor has one band of +/- 2% that is 100% MCO risk, with the State absorbing all of the risk outside of the first +/- 2%
3. The adjusted cost per prescription will be multiplied by the number of prescriptions provided by the MCO to calculate a normalized cost
4. The normalized cost will be compared to the funding received via the capitation rates based on the MCO-specific membership distribution
5. The difference between actual funding and normalized cost will be paid to/recouped from the MCOs