(iii) A managed care organization that does not comply with subparagraph (i) of this paragraph for at least 90% of its new enrollees:

1. Within 90 days of their enrollment may not receive more than 80% of its capitation payments;

2. Within 180 days of their enrollment may not receive more than 70% of its capitation payments; and

3. Within 270 days of their enrollment may not receive more than 50% of its capitation payments.

(13) The Department shall:

(i) Establish and maintain an ombudsman program and a locally accessible enrollee hotline;

(ii) Perform focused medical reviews of managed care organizations that include reviews of how the managed care organizations are providing health care services to special populations;

(iii) Provide timely feedback to each managed care organization on its compliance with the Department's quality and access system;

(iv) Establish and maintain within the Department a process for handling provider complaints about managed care organizations; and

(v) Adopt regulations relating to appeals by managed care organizations of penalties imposed by the Department, including regulations providing for an appeal to the Office of Administrative Hearings.

(14) (i) Except as provided in subparagraph (iii) of this paragraph, the Department shall delegate responsibility for maintaining the ombudsman program for a county to that county's local health department on the request of the local health department.

(ii) A local health department may not subcontract the ombudsman program.

(iii) Before the Department delegates responsibility to a local health department to maintain the ombudsman program for a county, a local health department that is also a Medicaid provider must receive the approval of the Secretary and the local governing body.

(15) A managed care organization may not:

(i) Without authorization by the Department, enroll an individual who at the time is a Program recipient; or

(ii) Have face–to–face or telephone contact, or otherwise solicit with an individual who at the time is a Program recipient before the Program recipient enrolls in the managed care organization unless:

1. Authorized by the Department; or