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**By: Chairman, Environmental Matters Committee (Departmental - Health and Mental Hygiene)**, and Delegates McHale, D. Davis, Ciliberti, Redmer, Hammen, Hurson, Fulton, Elliott, Hubbard, Frush, Stull, Morhaim, Oaks, Stup, and Nathan-Pulliam

Introduced and read first time: February 6, 1996
Assigned to: Environmental Matters

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 27, 1996

CHAPTER ____

AN ACT concerning

**Maryland Medical Assistance Program - Managed Care Organizations**

FOR the purpose of authorizing the Department of Health and Mental Hygiene to require Program recipients to enroll in managed care organizations; ~~authorizing the Department to prohibit managed care organizations from enrolling Program recipients;~~ authorizing the Department to require managed care organizations to include certain providers ~~who have historically served Program recipients~~; defining certain terms; altering certain terms and definitions; authorizing the Maryland Medical Assistance Program to provide guaranteed eligibility for recipients for a certain period under certain circumstances; prohibiting the benefitsrequired by the Program from exceeding a certain level; requiring the Program to provide services in accordance with certain restrictions; requiring certain managed careorganizations to provide certain services, submit certain reports and information,have quality assurance programs that meet certain criteria, pay hospitals at certain rates, and meet certain requirements for financial solvency; authorizing the Secretary of Health and Mental Hygiene to set and adjust certain payments with the approval of the Insurance Commissioner; prohibiting certain managed care organizations from enrolling and having certain contact with certain individuals exceptunder certain circumstances; providing that managed care organizations are subjectto certain provisions of law regarding health maintenance organizations; establishing a certain committee; establishing certain penalties for managed care organizations that do not meet certain standards; requiring the Department to establish a certain delivery system, establish certain programs, perform certain reviews, and adopt certain regulations; prohibiting the Department from implementing competitive bidding except under certain circumstances; repealing certain contingency provisions; requiring the Secretary to apply for a certain waiver or take certain steps; requiring

the Secretary to appear before certain committees of the General Assembly on a certain basis for a certain duration; requiring the Secretary and the State Department of Education to submit certain reports; requiring the Secretary to submit certain regulations to certain committees at least a certain number of days before submitting them to a certain committee; providing for the effective date of this Act; and generally relating to eligibility and managed care organizations ~~under~~ and the Maryland Medical Assistance Program.

BY repealing and reenacting, with amendments,
Article 48A - Insurance Code
Section 490S
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, without amendments,
Article 48A - Insurance Code
Section 490CC
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-101, 15-102(a), 15-102.1, 15-103(a) and (b), and 15-121.3
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)
(As enacted by Chapter 500 of the Acts of the General Assembly of 1995)

BY adding to
Article - Health - General
Section 15-102.2 and 15-102.3
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article - State Finance and Procurement
Section 11-101(n)
Annotated Code of Maryland
(1995 Replacement Volume and 1995 Supplement)
(As enacted by Chapter 500 of the Acts of the General Assembly of 1995)

BY repealing
Chapter 500 of the Acts of the General Assembly of 1995
Section 2, 3, and 4

BY repealing and reenacting, with amendments,
Chapter 500 of the Acts of the General Assembly of 1995

Section 5

Preamble

WHEREAS, The Secretary of Health and Mental Hygiene has conducted an extensive and lengthy public process in which members of a broad-based steering committee, legislators, consumers, providers, and others have had an opportunity to significantly influence the development of a proposal for mandatory enrollment of Medicaid recipients in managed care organizations; and

WHEREAS, After taking into consideration the opinions and comments of legislators, the steering committee, and members of the public, the Secretary has prepared a proposal to enroll Medicaid recipients in managed care organizations which he has submitted to the General Assembly for review and approval; and

WHEREAS, The General Assembly wishes to express its approval of the Secretary's proposal by enacting this legislation which will authorize the Secretary to implement said proposal and, in accordance with this Act, help enable the Department to obtain a waiver from the Health Care Financing Administration; and

WHEREAS, More than 120,000 Maryland Medical Assistance recipients ormore than 25% of the total Medical Assistance population have voluntarily enrolled in health maintenance organizations; and

WHEREAS, The General Assembly recognizes that federal spending caps for Medicaid are likely at some time in the future and that State tax revenues cannot support the high growth rates of the Medicaid Program in the past few years; and

WHEREAS, Placing Medicaid recipients in managed care organizations and capitating payments to those organizations will enable the State to meet spending caps which may be imposed by the federal government and to slow the rapid growth of the Medicaid Program; and

WHEREAS, The Secretary should have sufficient flexibility to modify his innovative managed care program as necessary during implementation so as to obtain the greatest amount of savings while assuring quality of care and access toservices; and

WHEREAS, The General Assembly recognizes the successes of the all-payor rate-setting system in the areas of cost containment, financial access,and equity and intends that the new system will support and complement the existing rate-setting system; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

**Article 48A - Insurance Code**

490S.

(a) All authorized insurers, including nonprofit health service plans, [and] fraternal benefit societies, AND MANAGED CARE ORGANIZATIONS AUTHORIZED TO RECEIVE MEDICAID PREPAID CAPITATION PAYMENTS UNDER TITLE 15, SUBTITLE 1

OF THE HEALTH - GENERAL ARTICLE, shall pay hospitals for hospital services rendered on the basis of the rate approved by the Health Services Cost Review Commission.

(b) (1) On or before March 1 of each year, each insurer that holds acertificate of authority in the State and provides health insurance in the State, each health maintenance organization that is licensed to operate in the State, [and] each nonprofit health service plan that is licensed to operate in the State, AND, AS APPLICABLE IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE COMMISSIONER, EACH MANAGED CARE ORGANIZATION THAT IS AUTHORIZED TO RECEIVE MEDICAID PREPAID CAPITATION PAYMENTS UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE, shall submit an annual report in a form required by the Commissioner that includes, for the preceding calendar year, the following data in the aggregate for all health benefit plans specific to this State:

(i) Premiums written;

(ii) Premiums earned;

(iii) Total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;

(iv) Total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, using estimates when necessary;

(v) Loss ratio; and

(vi) Expense ratio.

(2) (i) If the loss ratio of an insurer, other than an insurer that provides health insurance exclusively to individuals, or health maintenance organization, is less than 75 percent or if its expense ratio is more than 20 percent, the Commissioner may require the insurer or health maintenance organization to file new rates for its health benefit plans.

(ii) If the loss ratio of a nonprofit health service plan is less than 75 percent or if the expense ratio of a nonprofit health service plan is more than 18 percent, the Commissioner may require the nonprofit health service plan to file new rates for its health benefit plans.

(iii) The authority of the Commissioner to require an insurer to file new rates based on the insurer's loss ratio under this paragraph shall be deemed to be in addition to any other authority of the Commissioner under this article to require that rates not be excessive, inadequate, or unfairly discriminatory and may not be construed to limit any existing authority of the Commissioner to determine whether arate is excessive.

(3) In determining whether to require an insurer to file new rates under paragraph (2) of this subsection, the Commissioner may consider the amount of health insurance premiums earned in the State on individual policies in proportion to the total health insurance premiums earned in the State for the insurer. The insurer shall provide to the Commissioner the information necessary to make a determination of the proportion of individual premiums to total premiums as provided under this paragraph.

(C) (1) THE DATA REQUIRED UNDER SUBSECTION (B)(1) OF THIS SECTION FROM A MANAGED CARE ORGANIZATION OPERATING UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE SHALL BE REPORTED BY THE MANAGED CARE ORGANIZATION IN THE AGGREGATE.

(2) AS PART OF THE REPORT REQUIRED UNDER SUBSECTION (B) OF THIS SECTION, A MANAGED CARE ORGANIZATION SHALL:

(I) FILE A CONSOLIDATED FINANCIAL STATEMENT:

1. COVERING THE MANAGED CARE ORGANIZATION AND ALL OF ITS AFFILIATES AND SUBSIDIARIES; AND

2. CONSISTING OF THE FINANCIAL STATEMENTS PREPARED IN ACCORDANCE WITH STATUTORY ACCOUNTING PRINCIPLES OF THE MANAGED CARE ORGANIZATION AND ALL OF ITS AFFILIATES AND SUBSIDIARIES, CERTIFIED TO BY AN INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT AS TO THE FINANCIAL CONDITION, TRANSACTIONS, AND AFFAIRS OF THE MANAGED CARE ORGANIZATION AND ITS AFFILIATES AND SUBSIDIARIES FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR;

(II) PROVIDE A LIST OF THE TOTAL COMPENSATION FROM THE MANAGED CARE ORGANIZATION, INCLUDING ALL CASH AND DEFERRED COMPENSATION, STOCK, AND STOCK OPTIONS IN ADDITION TO SALARY, OF EACH MEMBER OF THE BOARD OF DIRECTORS OF THE MANAGED CARE ORGANIZATION, AND EACH SENIOR OFFICER OF THE MANAGED CARE ORGANIZATION OR ANY SUBSIDIARY OF THE MANAGED CARE ORGANIZATION AS DESIGNATED BY THE COMMISSIONER; AND

(III) PROVIDE ANY OTHER INFORMATION OR DOCUMENTS NECESSARY FOR THE COMMISSIONER TO ASSURE COMPLIANCE WITH THIS SUBSECTION AND FOR THE SECRETARY OF HEALTH AND MENTAL HYGIENE TO CARRY OUT TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

(3) BEFORE A MANAGED CARE ORGANIZATION MAY ENROLL A MARYLAND MEDICAL ASSISTANCE PROGRAM RECIPIENT, THE MANAGED CARE ORGANIZATION SHALL PROVIDE TO THE COMMISSIONER A BUSINESS PLAN ACCOMPANIED BY AN ACTUARIAL OPINION CONCERNING ITS FINANCIAL VIABILITY.

(4) CAPITATION PAYMENTS MAY BE ADJUSTED BY THE SECRETARY OF HEALTH AND MENTAL HYGIENE, WITH THE APPROVAL OF THE COMMISSIONER:

(I) FOR A MANAGED CARE ORGANIZATION, IF THE LOSS RATIO IS LESS THAN 80%; AND

(II) FOR A CERTIFIED HEALTH MAINTENANCE ORGANIZATION, IF THE LOSS RATIO RELATED TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM IS LESS THAN 80%.

(5) A LOSS RATIO REPORTED UNDER PARAGRAPH (4) OF THIS SUBSECTION SHALL BE CALCULATED SEPARATELY AND MAY NOT BE PART OF ANY OTHER LOSS RATIO REPORTED UNDER THIS SECTION.

(6) ANY REBATE RECEIVED BY A MANAGED CARE ORGANIZATION MAY NOT BE CONSIDERED PART OF THE LOSS RATIO OF THE MANAGED CARE ORGANIZATION.

(7) IF THE QUALITY OF CARE DELIVERED TO ENROLLEES FAILS TO MEET SPECIFICATIONS OF THE SECRETARY OF HEALTH AND MENTAL HYGIENE, THE MANAGED CARE ORGANIZATION MAY BE TERMINATED IN ACCORDANCE WITH § 15-103(B)(7) OF THE HEALTH - GENERAL ARTICLE.

490CC.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. An insurer;

2. A nonprofit health service plan;

3. A health maintenance organization;

4. A dental plan organization; or

5. Any other person or organization that provides health benefit plans subject to State regulation.

(ii) "Carrier" includes an entity that arranges a providerpanel for a carrier.

(3) "Enrollee" means any person entitled to health care benefits from a carrier.

(4) "Provider" means a health care practitioner or a group of health care practitioners licensed or otherwise authorized by law to provide healthcare services.

(5) (i) "Provider panel" means those providers with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(ii) "Provider panel" does not include an arrangement between a carrier and providers in which any provider may participate solely on the basis of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

(b) A carrier that uses a provider panel shall establish procedures for:

(1) Reviewing applications for participation in the carrier's provider panel in accordance with the provisions of this section;

(2) Notifying an enrollee of:

(i) The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee; and

(ii) The right of an enrollee upon request to continue to receive health care services for a period of up to 90 days from the date of a primary care provider's notice of termination from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the provider;

(3) Notifying primary care providers in the carrier's provider panel of the termination of a specialty referral services provider; and

(4) Notifying a provider at least 90 days prior to the date of the termination of the provider for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the provider.

(c) A carrier that uses a provider panel shall:

(1) Upon request, provide an application, and information relative to consideration for participation in the carrier's provider panel, to anyprovider wishing to apply for participation in the carrier's provider panel;

(2) Make publicly available its application; and

(3) Make efforts to increase the opportunity of a broad range of minority providers to participate in the carrier's provider panel.

(d) (1) A provider seeking participation in the provider panel of a carrier shall submit an application to the carrier.

(2) (i) After review by a carrier of an application submitted under paragraph (1) of this subsection, subject to the provisions of paragraph (3) of this subsection, the carrier shall accept or reject the provider for participation in the carrier's provider panel.

(ii) If the carrier rejects the provider for participationin the carrier's provider panel, the carrier shall send written notification of the rejection to the provider to the address listed on the application.

(3) (i) Except as provided in paragraph (4) of this subsection,within 30 days after the date of receipt by the carrier of a completed application, a carrier shall give written notice to the provider to the address listed on the applicationof:

1. The carrier's intent to continue to process the provider's application for purposes of obtaining necessary credentialing information; or

2. The carrier's rejection of the provider for participation in the carrier's provider panel.

(ii) Failure by a carrier to provide the written notification required under subparagraph (i) of this paragraph shall be considered a violation of this article and the carrier is subject to the penalties provided under § 55A of this article.

(iii) If a carrier provides written notice to the providerof its intent to continue to process the provider's application for purposes of obtaining the necessary credentialing information under subparagraph (i)1 of this paragraph, the carrier shall:

1. Within 150 days after the date the notice is provided, accept or reject the provider for participation in the carrier's provider panel; and

2. Send written notification to the address listed onthe application of the provider's acceptance or rejection for participationin the carrier's provider panel.

(iv) Failure of a carrier to send the written notificationrequired under subparagraph (iii) of this paragraph shall be considered a violation ofthis article and the carrier is subject to the provisions and penalties of §§ 55 and 55A of this article.

(4) (i) A carrier that receives an incomplete application submitted in accordance with paragraph (1) of this subsection shall return the application within 10 days from the date of receipt to the provider to the address listed on the application.

(ii) The carrier shall indicate to the provider what information is needed in order to make the application complete.

(iii) The provider may return the completed application tothe carrier.

(iv) After the carrier receives the completed application,the carrier is subject to the time periods established in paragraph (3) of this subsection.

(5) A carrier may charge a reasonable fee for any application that a provider submits to the carrier under this section.

(e) A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) Gender, race, age, religion, national origin, or a protected category under the Americans with Disabilities Act;

(2) The type or number of appeals filed by the provider under the provisions of Title 19, Subtitle 13 of the Health - General Article; or

(3) The type or the number of complaints or grievances the provider filed or requested for review under the carrier's internal review system.

(f) (1) A carrier may not deny an application for participation or terminate participation on its provider panel solely on the basis of the license,certification, or other authorization of the provider to provide services if the carrier provides services within the provider's lawful scope of practice.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, a carrier may reject an application for participation or terminate participation on the carrier's provider panel based on the participation on the carrier's provider panel by a sufficient number of similarly qualified providers.

(3) A violation of this subsection does not create a new cause of action.

(g) Each carrier shall establish an internal review system to resolve any grievances initiated by providers that are participating in the carrier's providerpanel, including grievances involving the termination of a provider from participation in the carrier's provider panel.

(h) A carrier may not terminate a provider from participation in thecarrier's provider panel, or otherwise penalize a provider, for:

(1) Advocating the interest of a patient through the carrier's internal review system; or

(2) Filing an appeal under the provisions of Title 19, Subtitle13 of the Health - General Article.

(i) (1) A carrier shall provide to a new member prior to enrollment and to existing enrollees at least once a year:

(i) A list of providers in its provider panel; and

(ii) Information with respect to providers who are no longer accepting new patients.

(2) The information provided under paragraph (1) of this subsection shall be updated at least once a year.

(3) The evidence of coverage, policy, or certificate shall:

(i) Clearly indicate the office within the Administration that is responsible for receiving and responding to enrollee's complaints concerning carriers; and

(ii) Include the telephone number of the office and the process for filing a complaint.

(j) (1) For a period of at least 90 days from the date of the noticeof a primary care provider's termination from the carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the primary care provider, the primary care provider shall render health care services to any of the carrier's enrollees who:

(i) Were receiving health care services from the primary care provider prior to the notice of termination; and

(ii) Request, after receiving notice of the primary care provider's termination under subsection (b) of this section, to continue receivinghealth care services from the primary care provider.

(2) A carrier shall reimburse the primary care provider under this subsection in accordance with the provider's agreement with the carrier.

(k) The Commissioner shall:

(1) Adopt regulations concerning the application process that carriers shall use to process applications for participation in a carrier's provider panel; and

(2) In consultation with the Secretary of Health and Mental Hygiene, adopt strategies that would assist carriers in maximizing the opportunity of a broad range of minority providers to participate in the delivery of health care services.

**Article - Health - General**

15-101.

(a) In this title the following words have the meanings indicated.

(B) "ENROLLEE" MEANS A PROGRAM RECIPIENT WHO IS ENROLLED IN A MANAGED CARE ORGANIZATION.

~~(b)~~ (C) "Facility" means a hospital or nursing facility including anintermediate care facility, skilled nursing facility, comprehensive care facility, or extended care facility.

(D) (1) "HISTORIC PROVIDER" MEANS A HEALTH CARE PROVIDER, AS DEFINED UNDER § 19-1501 OF THIS ARTICLE WHO, ON OR BEFORE JANUARY 1, 1996, HAD A DEMONSTRATED HISTORY OF PROVIDING SERVICES TO PROGRAM RECIPIENTS, AS DEFINED BY THE DEPARTMENT IN REGULATIONS.

(2) "HISTORIC PROVIDER" MAY INCLUDE:

(I) A FEDERAL OR STATE QUALIFIED COMMUNITY HEALTH CENTER;

(II) A PROVIDER WITH A PROGRAM FOR THE TRAINING OF HEALTH CARE PROFESSIONALS, INCLUDING AN ACADEMIC MEDICAL CENTER;

(III) A HOSPITAL OUTPATIENT PROGRAM, PHYSICIAN, OR ADVANCED PRACTICE NURSE THAT IS A MARYLAND ACCESS TO CARE (MAC) PROVIDER;

(IV) A LOCAL HEALTH DEPARTMENT;

(V) A PHARMACY; AND

(VI) ANY OTHER HISTORIC PROVIDER DESIGNATED IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE DEPARTMENT.

~~(c)~~ (E) "Managed care [plan] ORGANIZATION" means:

(1) A certified health maintenance organization THAT IS AUTHORIZED TO RECEIVE MEDICAL ASSISTANCE PREPAID CAPITATION PAYMENTS; OR

~~(2) A managed care system that is not a health maintenance organization and does not hold a certificate of authority to operate as an insurer but is authorized UNDER FEDERAL LAW OR WAIVER to receive MEDICAID prepaid capitation payments AND IS subject to the regulatory solvency requirements, appropriate forthe risk to be assumed, adopted by the Insurance Commissioner in consultation with theSecretary; or~~

(2) A CORPORATION THAT:

(I) IS A MANAGED CARE SYSTEM THAT IS AUTHORIZED TO RECEIVE MEDICAL ASSISTANCE PREPAID CAPITATION PAYMENTS;

(II) ENROLLS ONLY PROGRAM RECIPIENTS; AND

(III) IS SUBJECT TO THE REGULATORY SOLVENCY REQUIREMENTS THAT WOULD BE APPLICABLE TO A HEALTH MAINTENANCE ORGANIZATION UNDER § 19-710 OF THIS ARTICLE.

(3) ~~A~~ "MANAGED CARE ORGANIZATION" DOES NOT INCLUDE A program that provides services to individuals under Title 7, Subtitle 3, Title 7, Subtitle 7, § 8-204, Title 8, Subtitle 4, Title 10, Subtitle 9, or Title 10, Subtitle 12 of this article.

(F) "OMBUDSMAN PROGRAM" MEANS A PROGRAM THAT:

(1) INVESTIGATES AND ASSISTS ENROLLEES IN RESOLVING DISPUTES WITH MANAGED CARE ORGANIZATIONS IN A TIMELY MANNER;

(2) INVESTIGATES DISPUTES BETWEEN ENROLLEES AND MANAGED CARE ORGANIZATIONS REFERRED BY THE ENROLLEE HOTLINE;

(3) REPORTS TO THE DEPARTMENT THE RESOLUTION OF ALL COMPLAINTS, THE FAILURE OF A MANAGED CARE ORGANIZATION TO MEET THE REQUIREMENTS OF THE DEPARTMENT AND ANY OTHER INFORMATION SPECIFIED BY THE DEPARTMENT;

(4) EDUCATES ENROLLEES ABOUT THE SERVICES PROVIDED BY THE ENROLLEE'S MANAGED CARE ORGANIZATION AND THE ENROLLEE'S RIGHTS AND RESPONSIBILITIES IN RECEIVING SERVICES FROM THE MANAGED CARE ORGANIZATION; AND

(5) ADVOCATES ON BEHALF OF ENROLLEES BEFORE THE MANAGED CARE ORGANIZATION AND ASSISTS ENROLLEES IN USING THE MANAGED CARE ORGANIZATION'S GRIEVANCE PROCESS.

(G) (1) "PRIMARY MENTAL HEALTH SERVICES" MEANS CLINICAL EVALUATION AND ASSESSMENT OF SERVICES NEEDED BY AN INDIVIDUAL, PROVISION OF SERVICES OR REFERRAL FOR ADDITIONAL SERVICES AS DEEMED MEDICALLY APPROPRIATE BY A PRIMARY CARE PROVIDER.

(2) "PRIMARY MENTAL HEALTH SERVICES" DOES NOT INCLUDE DRUG AND ALCOHOL REHABILITATION SERVICES.

~~(d)~~ (H) "Program" means the Maryland Medical Assistance Program.

~~(e)~~ (I) "Program recipient" means an individual who receives benefits under the Program.

(J) "SPECIALTY MENTAL HEALTH SERVICES" MEANS ANY MENTAL HEALTH SERVICES OTHER THAN PRIMARY MENTAL HEALTH SERVICES.

15-102.

(a) Subject to the limitations of the State budget [and the availability of federal funds], the Department shall provide preventive and home care services for indigent and medically indigent individuals.

15-102.1.

(a) The General Assembly finds that it is a goal of this State to promote the development of a health care system that provides adequate and appropriate health care SERVICES to indigent and medically indigent individuals.

(b) The Department shall, to the extent permitted, subject to the limitations of the State budget [and the availability of federal funds]:

(1) Provide a comprehensive system of quality health care SERVICES with an emphasis on prevention, education, individualized care, and appropriate case management;

(2) Develop a prenatal care program for Program recipients and encourage its utilization;

(3) Allocate State resources for the Program to provide a balanced system of health care SERVICES to the population served by the Program;

(4) Seek to coordinate the Program activities with other State programs and initiatives that are necessary to address the health care needs of the population served by the Program;

(5) Promote Program policies that facilitate access to and continuity of care by encouraging:

(i) Provider availability throughout the State;

(ii) Consumer education;

(iii) The development of ongoing relationships between Program recipients and primary health care providers; and

(iv) The regular review of the Program's regulations to determine whether the administrative requirements of those regulations are unnecessarily burdensome on Program providers;

(6) Strongly urge health care providers to participate in the Program and thereby address the needs of Program recipients;

(7) Require health care providers who participate in the Program to provide access to Program recipients on a nondiscriminatory basis in accordancewith State and federal law;

(8) Seek to provide appropriate levels of reimbursement for providers to encourage greater participation by providers in the Program;

(9) Promote individual responsibility for maintaining good health habits;

(10) Encourage the Program and Maryland's Health Care Regulatory System to work to cooperatively promote the development of an appropriate mix of health care providers, limit cost increases for the delivery of health care to Program recipients, and ~~insure~~ ENSURE the delivery of quality health care to Program recipients;

(11) Encourage the development and utilization of cost-effective and preventive alternatives to the delivery of health care services to appropriate Program recipients in inpatient institutional settings;

(12) Encourage the appropriate executive agencies to coordinatethe eligibility determination, policy, operations, and compliance components of the Program;

(13) Work with representatives of inpatient institutions, thirdparty payors, and the appropriate State agencies to contain Program costs;

(14) Identify and seek to develop an optimal mix of State, federal, and privately financed health care services for Program recipients, within available resources through cooperative interagency efforts;

(15) Develop joint legislative and executive branch strategies to persuade the federal government to reconsider those policies that discourage the delivery of cost effective health care SERVICES to Program recipients;

(16) Evaluate departmental recommendations as to those persons whose financial need or health care needs are most acute;

(17) Establish mechanisms for aggressively pursuing recoveries against third parties permitted under current law and exploring additional methods for seeking to recover other moneys expended by the Program; and

(18) Take appropriate measures to assure the quality of health care SERVICES provided by managed care [plans] ORGANIZATIONS.

15-102.2.

(A) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE PROVISIONS OF § 19-706.1 OF THIS ARTICLE (REHABILITATION AND LIQUIDATION) SHALL APPLYTO MANAGED CARE ORGANIZATIONS IN THE SAME MANNER THEY APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

(B) (1) A HEALTH CARE PROVIDER MAY NOT ASSERT A CLAIM OF SUBROGATION AGAINST AN ENROLLEE OF A MANAGED CARE ORGANIZATION OR THE STATE.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, A HEALTH CARE PROVIDER MAY ASSERT ANY CLAIM IT MAY HAVE AGAINST THE RECEIVER OF THE INSOLVENT MANAGED CARE ORGANIZATION.

15-102.3.

THE PROVISIONS OF § 19-712.1 OF THIS ARTICLE (PROMPT PAYMENT) SHALL APPLY TO MANAGED CARE ORGANIZATIONS IN THE SAME MANNER THEY APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

15-103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(2) The Program:

(i) Subject to the limitations of the State budget [and the availability of federal funds], shall provide comprehensive medical and other healthcare SERVICES for indigent individuals or medically indigent individuals or both;

(ii) Shall provide, subject to the limitations of the State budget [and the availability of federal funds], comprehensive medical and other health care SERVICES for all ~~QUALIFYING~~ ELIGIBLE pregnant women and, at a minimum, all children currently under the age of 1 whose family income falls below 185 percent of the poverty level, as permitted by the federal law;

(iii) Shall provide, subject to the limitations of the State budget, family planning [service] SERVICES to women currently eligible for comprehensive medical care and other health care under item (ii) of this paragraph for 5 years after the second month following the month in which the woman delivers her child;

(iv) Shall provide, subject to the limitations of the State budget [and the availability of federal funds], comprehensive medical and other health care SERVICES for all children from the age of 1 year up through and including the age of 5 years whose family income falls below 133 percent of the poverty level,as permitted by the federal law;

(v) Shall provide, subject to the limitations of the Statebudget [and the availability of federal funds], comprehensive medical care and other health care SERVICES for all children born after September 30, 1983 who are at least 6 years of age but are under 19 years of age whose family income falls below 100 percent of the poverty level, as permitted by federal law; [and]

~~(VI) MAY PROVIDE, SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND AS PERMITTED BY FEDERAL LAW OR WAIVER, GUARANTEED ELIGIBILITY FOR A PERIOD NOT TO EXCEED 6 MONTHS; AND~~

(VI) SHALL PROVIDE SERVICES IN ACCORDANCE WITH FUNDING RESTRICTIONS INCLUDED IN THE ANNUAL STATE BUDGET BILL; AND

[(vi)] (VII) May include bedside nursing care for eligible Program recipients.

(3) Subject to restrictions in federal law or waivers, the Department may impose cost-sharing on Program recipients.

(b) (1) [The] AS PERMITTED BY FEDERAL LAW OR WAIVER, THE Secretary may establish a program under which Program recipients are required to enroll in managed care [plans] ORGANIZATIONS.

(2) (I) THE BENEFITS REQUIRED BY THE PROGRAM DEVELOPED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE ADOPTED BY REGULATION AND MAY NOT EXCEED THE BENEFIT LEVEL REQUIRED BY THE MARYLAND MEDICAL ASSISTANCE PROGRAM ON JANUARY 1, 1996.

(II) NOTHING IN THIS PARAGRAPH MAY BE CONSTRUED TO PROHIBIT A MANAGED CARE ORGANIZATION FROM OFFERING ADDITIONAL

BENEFITS, IF THE MANAGED CARE ORGANIZATION IS NOT RECEIVING CAPITATION PAYMENTS BASED ON THE PROVISION OF THE ADDITIONAL BENEFITS.

(3) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND AS PERMITTED BY FEDERAL LAW OR WAIVER, THE PROGRAM DEVELOPED UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY PROVIDE GUARANTEED ELIGIBILITY FOR EACH ENROLLEE FOR UP TO 6 MONTHS, UNLESS AN ENROLLEE OBTAINS HEALTH INSURANCE THROUGH ANOTHER SOURCE.

(4) (I) THE SECRETARY MAY EXCLUDE SPECIFIC POPULATIONS OR SERVICES FROM THE PROGRAM DEVELOPED UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(II) FOR ANY POPULATIONS OR SERVICES EXCLUDED UNDER THIS PARAGRAPH, THE SECRETARY MAY AUTHORIZE A MANAGED CARE ORGANIZATION, TO PROVIDE THE SERVICES OR PROVIDE FOR THE POPULATION, INCLUDING AUTHORIZATION OF A SEPARATE DENTAL MANAGED CARE ORGANIZATION OR A MANAGED CARE ORGANIZATION TO PROVIDE SERVICES TO PROGRAM RECIPIENTS WITH SPECIAL NEEDS.

(5) (I) EXCEPT FOR A POPULATION OR SERVICE EXCLUDED BY THE SECRETARY UNDER PARAGRAPH (4) OF THIS SUBSECTION, EACH MANAGED CARE ORGANIZATION SHALL PROVIDE ALL THE BENEFITS REQUIRED BY REGULATIONS ADOPTED UNDER PARAGRAPH (2) OF THIS SUBSECTION.

(II) FOR A POPULATION OR SERVICE EXCLUDED BY THE SECRETARY UNDER PARAGRAPH (4) OF THIS SUBSECTION, THE SECRETARY MAY AUTHORIZE A MANAGED CARE ORGANIZATION TO PROVIDE ONLY FOR THAT POPULATION OR PROVIDE ONLY THAT SERVICE.

(III) A MANAGED CARE ORGANIZATION MAY SUBCONTRACT SPECIFIED REQUIRED SERVICES TO A HEALTH CARE PROVIDER THAT IS LICENSED OR AUTHORIZED TO PROVIDE THOSE SERVICES.

(6) FOR CAUSE, THE DEPARTMENT MAY DISENROLL ENROLLEES FROM A MANAGED CARE ORGANIZATION AND ENROLL THEM IN ANOTHER MANAGED CARE ORGANIZATION.

~~(2)~~ (7) A managed care [plan] ORGANIZATION shall:

(i) Have a quality assurance program in effect which is subject to the approval of the Department~~;~~ AND WHICH, AT A MINIMUM:

1. COMPLIES WITH ANY HEALTH CARE QUALITY IMPROVEMENT SYSTEM DEVELOPED BY THE HEALTH CARE FINANCING ADMINISTRATION;

2. COMPLIES WITH THE QUALITY REQUIREMENTS OF APPLICABLE STATE LICENSURE LAW AND REGULATIONS;

3. COMPLIES WITH PRACTICE GUIDELINES AND PROTOCOLS SPECIFIED BY THE DEPARTMENT IN REGULATIONS;

4. COMPLIES WITH SPECIFIC QUALITY, ACCESS, DATA, AND PERFORMANCE MEASUREMENTS ADOPTED BY THE DEPARTMENT IN COLLABORATION WITH MANAGED CARE ORGANIZATIONS FOR TREATING ENROLLEES WITH SPECIAL NEEDS;

5. PROVIDES AN ENROLLEE GRIEVANCE SYSTEM THAT INCLUDES AN ENROLLEE HOTLINE;

6. PROVIDES A PROVIDER GRIEVANCE SYSTEM;

7. PROVIDES FOR ENROLLEE AND PROVIDER SATISFACTION SURVEYS AT LEAST ANNUALLY; AND

8. PROVIDES FOR A CONSUMER ADVISORY BOARD TO RECEIVE REGULAR INPUT FROM ENROLLEES;

(ii) ~~Collect and submit~~ SUBMIT to the Department ~~service-specific data by service type in a format to be established by the Department~~ THE HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS) AND OTHER UTILIZATION AND OUTCOME REPORTS AS REQUIRED BY THE DEPARTMENT IN CONSULTATION WITH MANAGED CARE ORGANIZATIONS;

(iii) Promote timely access to and continuity of health care SERVICES for ~~Program recipients~~ ENROLLEES;

~~(iv) Develop special programs tailored to meet the individual health care needs of Program recipients;~~

(IV) DEMONSTRATE THE ORGANIZATIONAL CAPACITY TO PROVIDE COVERED SERVICES AND SPECIAL PROGRAMS, INCLUDING OUTREACH, CASE MANAGEMENT, AND HOME VISITING, TAILORED TO MEET THE INDIVIDUAL NEEDS OF ALL ENROLLEES;

(v) Provide assistance to ~~Program recipients~~ ENROLLEES in securing necessary health care services;

(vi) Provide or assure alcohol and drug abuse treatment for substance abusing pregnant women AND ALL OTHER ENROLLEES OF MANAGED CARE ORGANIZATIONS WHO REQUIRE THESE SERVICES;

(vii) Educate ~~Program recipients~~ ENROLLEES on health care prevention and good health habits;

(viii) Assure necessary provider capacity in all geographic areas under contract;

(IX) PROVIDE LOCALLY, TO THE EXTENT THE SERVICES ARE AVAILABLE LOCALLY, COVERED SERVICES;

~~(ix)~~ (X) Be accountable AND HOLD ITS SUBCONTRACTORS ACCOUNTABLE for standards established by the Department UNDER THIS TITLE and, upon failure to meet those standards, be subject to ~~a penalty up to and~~including

~~revocation of its Medicaid managed care contract; and~~ ONE OR MORE OF THE FOLLOWING PENALTIES:

1. FINES;

2. SUSPENSION OF FURTHER ENROLLMENTS;

3. WITHHOLDING OF ALL OR PART OF CAPITATION PAYMENTS;

4. TERMINATION OF THE CONTRACT;

5. DISQUALIFICATION FROM FUTURE PARTICIPATION IN THE PROGRAM; AND

6. ANY OTHER PENALTY IMPOSED BY THE DEPARTMENT;

~~(x)~~ (XI) Subject to applicable federal and State law, include incentives for ~~Program recipients~~ ENROLLEES to comply with provisions of the managed care [plan] ORGANIZATION~~[~~, and disincentives for failing to comply with provisions of the managed care ~~plan~~ ORGANIZATION~~]~~.;

(XII) PROVIDE OR ARRANGE TO PROVIDE PRIMARY MENTAL HEALTH SERVICES;

(XIII) EMPLOY CASE MANAGERS TO:

1. ENSURE THAT INDIVIDUALS WITH SPECIAL NEEDS OBTAIN NEEDED SERVICES; AND

2. COORDINATE THOSE SERVICES;

(XIV) PROVIDE, OR ARRANGE TO PROVIDE ALL MEDICAID-COVERED SERVICES REQUIRED TO COMPLY WITH STATE STATUTES AND REGULATIONS MANDATING HEALTH AND MENTAL HEALTH SERVICES FOR CHILDREN IN STATE-SUPERVISED CARE:

1. ACCORDING TO STANDARDS SET BY THE DEPARTMENT; AND

2. LOCALLY, TO THE EXTENT THE SERVICES ARE AVAILABLE LOCALLY; AND

(XV) SUBMIT TO THE DEPARTMENT IN THE AGGREGATE INFORMATION FROM ITS QUALITY ASSURANCE PROGRAM, INCLUDING COMPLAINTS AND RESOLUTIONS FROM THE ENROLLEE AND PROVIDER GRIEVANCE SYSTEMS SATISFACTION SURVEYS, AND THE ENROLLEE HOTLINE.

(8) (I) A MANAGED CARE ORGANIZATION SHALL REIMBURSE A HOSPITAL EMERGENCY FACILITY AND PROVIDER FOR:

1. SERVICES THAT MEET THE DEFINITION OF EMERGENCY SERVICES UNDER § 19-701(D) OF THIS ARTICLE;

2. MEDICAL SCREENING SERVICES RENDERED TO MEET THE REQUIREMENTS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT;

3. MEDICALLY NECESSARY SERVICES IF THE MANAGED CARE ORGANIZATION AUTHORIZED, DIRECTED, REFERRED, OR OTHERWISE ALLOWED AN ENROLLEE TO USE THE EMERGENCY FACILITY AND THE MEDICALLY NECESSARY SERVICES ARE RELATED TO THE CONDITION FOR WHICH THE ENROLLEE WAS ALLOWED TO USE THE EMERGENCY FACILITY; AND

4. MEDICALLY NECESSARY SERVICES THAT RELATE TO THE CONDITION PRESENTED AND THAT ARE PROVIDED BY THE PROVIDER IN THE EMERGENCY FACILITY TO AN ENROLLEE IF THE MANAGED CARE ORGANIZATION FAILS TO PROVIDE 24-HOUR ACCESS AS REQUIRED BY THE DEPARTMENT.

(II) A PROVIDER MAY NOT BE REQUIRED TO OBTAIN PRIOR AUTHORIZATION OR APPROVAL FOR PAYMENT FROM A MANAGED CARE ORGANIZATION IN ORDER TO OBTAIN REIMBURSEMENT UNDER THIS PARAGRAPH.

[(3) The Secretary shall ensure participation in the development of the managed care program by the involvement of a broad-based steering committee including legislative, consumer, and provider representation.

(4) The Secretary shall submit to the Senate Finance Committee and House Environmental Matters Committee of the General Assembly for their review any proposals developed under paragraph (1) of this subsection prior to requesting approval by the U.S. Department of Health and Human Services under § 1115 of theSocial Security Act.]

~~(3) THE SECRETARY MAY PROHIBIT MANAGED CARE ORGANIZATIONS FROM ENROLLING PROGRAM RECIPIENTS.~~

(9) A MANAGED CARE ORGANIZATION MAY NOT:

(I) ENROLL AN INDIVIDUAL WHO AT THE TIME IS A PROGRAM RECIPIENT UNLESS AUTHORIZED TO DO SO BY THE DEPARTMENT; OR

(II) HAVE FACE-TO-FACE OR TELEPHONE CONTACT WITH OR OTHERWISE SOLICIT AN INDIVIDUAL WHO IS ELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM BEFORE THE INDIVIDUAL HAS CHOSEN A MANAGED CARE ORGANIZATION UNLESS:

1. AUTHORIZED TO DO SO BY THE DEPARTMENT; OR

2. THE INDIVIDUAL INITIATES CONTACT.

(10) (I) THE DEPARTMENT SHALL BE RESPONSIBLE FOR ENROLLING PROGRAM RECIPIENTS INTO MANAGED CARE ORGANIZATIONS.

(II) THE DEPARTMENT MAY CONTRACT WITH AN ENTITY TO PERFORM THE ENROLLMENT FUNCTION.

(III) THE DEPARTMENT OR ITS ENROLLMENT CONTRACTOR SHALL ADMINISTER A HEALTH RISK ASSESSMENT DEVELOPED BY THE DEPARTMENT TO ENSURE THAT INDIVIDUALS WHO NEED SPECIAL OR IMMEDIATE HEALTH CARE SERVICES WILL RECEIVE THE SERVICES ON A TIMELY BASIS.

(IV) THE DEPARTMENT OR ITS ENROLLMENT CONTRACTOR:

1. MAY ADMINISTER THE HEALTH RISK ASSESSMENT ONLY AFTER THE PROGRAM RECIPIENT HAS CHOSEN A MANAGED CARE ORGANIZATION; AND

2. SHALL FORWARD THE RESULTS OF THE HEALTH RISK ASSESSMENT TO THE MANAGED CARE ORGANIZATION CHOSEN BY THE PROGRAM RECIPIENT WITHIN 5 BUSINESS DAYS.

~~[(5)] (4) (i) The Secretary may exclude specific populations or services from any program developed under paragraph (1) of this subsection.~~

~~(ii) The Secretary may establish a managed care program for any population or service excluded under subparagraph (i) of this paragraph.~~

~~[(6)] (5) For a managed care [plan] ORGANIZATION with which the Secretary contracts to provide services to Program recipients under this subsection, the Secretary may require as a condition of that contract that the managed care [plan] ORGANIZATION include[, to the extent economically feasible, particular providers in providing those services in the following circumstances:~~

~~(i) In areas that have been served historically by a community health center, the Secretary may require a managed care plan to include that community health center in its delivery of service to Program recipients who have traditionally obtained health care services through that community health center;~~

~~(ii) For providers with residency programs for the training of health care professionals, the Secretary may require a managed care plan to include those providers in its delivery of service to Program recipients; and~~

~~(iii) In other circumstances to meet particular needs of Program recipients or the community being served as provided in regulations adopted by the Secretary.] PROVIDERS WHO HAVE HISTORICALLY SERVED PROGRAM RECIPIENTS, IN ACCORDANCE WITH REGULATIONS ISSUED BY THE SECRETARY.~~

(11) THE SECRETARY SHALL ESTABLISH A MECHANISM TO INITIALLY ENSURE THAT EACH HISTORIC PROVIDER CONTINUES TO SERVE PROGRAM RECIPIENTS AS A SUBCONTRACTOR OF AT LEAST ONE MANAGED CARE ORGANIZATION IF THE HISTORIC PROVIDER MEETS QUALITY STANDARDS ESTABLISHED BY THE DEPARTMENT IN CONSULTATION WITH MANAGED CARE ORGANIZATIONS.

(12) THE PROVISIONS OF ARTICLE 48A, § 490CC OF THE CODE (PROVIDER PARTICIPATION STANDARDS) APPLY TO MANAGED CARE ORGANIZATIONS IN THE SAME MANNER THEY APPLY TO CARRIERS.

(13) EACH MANAGED CARE ORGANIZATION SHALL SUBMIT TO THE SECRETARY THE INFORMATION THE MANAGED CARE ORGANIZATION MUST SUBMIT TO THE INSURANCE COMMISSIONER UNDER ARTICLE 48A, § 490S OF THE CODE.

(14) (I) THE DEPARTMENT SHALL MAKE CAPITATION PAYMENTS TO EACH MANAGED CARE ORGANIZATION AS PROVIDED IN THIS PARAGRAPH.

(II) WITH THE APPROVAL OF THE INSURANCE COMMISSIONER, THE SECRETARY SHALL:

1. SET CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS AT A LEVEL THAT IS ACTUARIALLY RELATED TO THE BENEFITS PROVIDED; AND

2. ACTUARIALLY ADJUST THE CAPITATION PAYMENTS TO REFLECT THE RELATIVE RISK ASSUMED BY THE MANAGED CARE ORGANIZATION.

(III) UNLESS THE INSURANCE COMMISSIONER DISAPPROVES THE LEVEL OF CAPITATION PAYMENTS, THE LEVEL OF CAPITATION PAYMENTS BECOMES EFFECTIVE WITHIN 60 DAYS AFTER THE COMMISSIONER RECEIVES THE PROPOSAL.

(15) (I) MANAGED CARE ORGANIZATIONS AND SCHOOL-BASED CLINICS SHALL COLLABORATE TO PROVIDE CONTINUITY OF CARE TO ENROLLEES.

(II) SCHOOL-BASED CLINICS SHALL BE DEFINED BY THE DEPARTMENT IN CONSULTATION WITH THE STATE DEPARTMENT OF EDUCATION.

(III) EACH MANAGED CARE ORGANIZATION SHALL REQUIRE A SCHOOL-BASED CLINIC TO PROVIDE TO THE MANAGED CARE ORGANIZATION CERTAIN INFORMATION, AS SPECIFIED BY THE DEPARTMENT, ABOUT AN ENCOUNTER WITH AN ENROLLEE OF THE MANAGED CARE ORGANIZATION PRIOR TO PAYING THE SCHOOL-BASED CLINIC.

(IV) UPON RECEIPT OF INFORMATION SPECIFIED BY THE DEPARTMENT, THE MANAGED CARE ORGANIZATION SHALL PAY, AT MEDICAID-ESTABLISHED RATES, SCHOOL-BASED CLINICS FOR COVERED SERVICES PROVIDED TO ENROLLEES OF THE MANAGED CARE ORGANIZATION.

(V) THE DEPARTMENT SHALL WORK WITH MANAGED CARE ORGANIZATIONS AND SCHOOL-BASED CLINICS TO DEVELOP COLLABORATION STANDARDS, GUIDELINES, AND A PROCESS TO ASSURE THAT THE SERVICES PROVIDED ARE COVERED AND MEDICALLY APPROPRIATE AND THAT THE PROCESS PROVIDES FOR TIMELY NOTIFICATION AMONG THE PARTIES.

(VI) EACH MANAGED CARE ORGANIZATION SHALL MAINTAIN RECORDS OF ALL HEALTH CARE SERVICES:

1. PROVIDED TO ITS ENROLLEES BY SCHOOL-BASED CLINICS; AND

2. FOR WHICH THE MANAGED CARE ORGANIZATION HAS BEEN BILLED.

(16) (I) EACH MANAGED CARE ORGANIZATION SHALL NOTIFY EACH ENROLLEE WHEN THE ENROLLEE SHOULD OBTAIN AN IMMUNIZATION, EXAMINATION, OR OTHER WELLNESS SERVICE.

(II) MANAGED CARE ORGANIZATIONS SHALL:

1. MAINTAIN EVIDENCE OF COMPLIANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH; AND

2. UPON REQUEST BY THE DEPARTMENT, PROVIDE TO THE DEPARTMENT EVIDENCE OF COMPLIANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH.

(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.

(17) THE DEPARTMENT SHALL:

(I) 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;

(II) PROVIDE TIMELY FEEDBACK TO EACH MANAGED CARE ORGANIZATION ON ITS COMPLIANCE WITH THE DEPARTMENT'S QUALITY AND ACCESS STANDARDS;

(III) ESTABLISH AND MAINTAIN WITHIN THE DEPARTMENT A PROCESS FOR HANDLING PROVIDER COMPLAINTS ABOUT MANAGED CARE ORGANIZATIONS; AND

(IV) ESTABLISH AN APPEALS PROCESS FOR MANAGED CARE ORGANIZATIONS RELATING TO FINES AND OTHER PENALTIES IMPOSED BY THE DEPARTMENT.

(18) (I) THE DEPARTMENT SHALL ESTABLISH AND MAINTAIN AN OMBUDSMAN PROGRAM AND A LOCALLY ACCESSIBLE ENROLLEE HOTLINE.

(II) EXCEPT AS OTHERWISE PROVIDED IN THIS PARAGRAPH, THE DEPARTMENT MAY DELEGATE RESPONSIBILITY FOR THE OMBUDSMAN PROGRAM TO A LOCAL HEALTH DEPARTMENT ON REQUEST OF THE LOCAL HEALTH DEPARTMENT.

(III) A LOCAL HEALTH DEPARTMENT MAY NOT SUBCONTRACT THE OMBUDSMAN PROGRAM.

(19) THE DEPARTMENT, IN CONSULTATION WITH MANAGED CARE ORGANIZATIONS, SHALL PREPARE AND MAKE AVAILABLE TO ENROLLEES A SUMMARY OF THE MANAGED CARE ORGANIZATION QUALITY ASSURANCE PROGRAM REQUIREMENTS.

(20) THE DEPARTMENT SHALL ADOPT REGULATIONS THAT ESTABLISH:

(I) STANDARDS FOR THE TIMELY DELIVERY OF SERVICES TO ENROLLEES; AND

(II) APPROPRIATE PENALTIES FOR FAILURE TO MEET THE STANDARDS.

(21) (I) THE DEPARTMENT SHALL ADOPT REGULATIONS RELATING TO ENROLLMENT, DISENROLLMENT, AND APPEALS.

(II) AN ENROLLEE MAY DISENROLL FROM A MANAGED CARE ORGANIZATION:

1. WITHOUT CAUSE IN THE MONTH FOLLOWING THE ANNIVERSARY DATE OF THE ENROLLEE'S ENROLLMENT; AND

2. FOR CAUSE, AT ANY TIME AS DETERMINED BY THE SECRETARY.

(22) (I) THE DEPARTMENT SHALL ESTABLISH A DELIVERY SYSTEM FOR SPECIALTY MENTAL HEALTH SERVICES FOR ENROLLEES OF MANAGED CARE ORGANIZATIONS.

(II) THE MENTAL HYGIENE ADMINISTRATION SHALL:

1. DESIGN AND MONITOR THE DELIVERY SYSTEM;

2. ESTABLISH PERFORMANCE STANDARDS FOR PROVIDERS IN THE DELIVERY SYSTEM; AND

3. ESTABLISH PROCEDURES TO ENSURE APPROPRIATE AND TIMELY REFERRALS FROM MANAGED CARE ORGANIZATIONS TO THE DELIVERY SYSTEM THAT INCLUDE:

A. SPECIFICATION OF THE DIAGNOSES AND CONDITIONS ELIGIBLE FOR REFERRAL TO THE DELIVERY SYSTEM;

B. TRAINING AND CLINICAL GUIDANCE IN APPROPRIATE USE OF THE DELIVERY SYSTEM FOR MANAGED CARE ORGANIZATION PRIMARY CARE PROVIDERS;

C. PREAUTHORIZATION BY THE UTILIZATION REVIEW AGENT OF THE DELIVERY SYSTEM; AND

D. PENALTIES FOR A PATTERN OF IMPROPER REFERRALS.

(III) THE DEPARTMENT SHALL COLLABORATE WITH MANAGED CARE ORGANIZATIONS TO DEVELOP STANDARDS AND GUIDELINES FOR THE PROVISION OF SPECIALTY MENTAL HEALTH SERVICES.

(IV) THE DELIVERY SYSTEM SHALL:

1. PROVIDE ALL SPECIALTY MENTAL HEALTH SERVICES NEEDED BY ENROLLEES;

2. FOR ENROLLEES WHO ARE DUALLY-DIAGNOSED, COORDINATE THE PROVISION OF SUBSTANCE ABUSE SERVICES PROVIDED BY THE MANAGED CARE ORGANIZATIONS OF THE ENROLLEES;

3. CONSIST OF A NETWORK OF QUALIFIED MENTAL HEALTH PROFESSIONALS FROM ALL CORE DISCIPLINES;

4. INCLUDE LINKAGES WITH OTHER PUBLIC SERVICE SYSTEMS; AND

5. COMPLY WITH QUALITY ASSURANCE, ENROLLEE INPUT, DATA COLLECTION, AND OTHER REQUIREMENTS SPECIFIED BY THE DEPARTMENT IN REGULATION.

(V) THE DEPARTMENT MAY CONTRACT WITH A MANAGED CARE ORGANIZATION FOR DELIVERY OF SPECIALTY MENTAL HEALTH SERVICES IF THE MANAGED CARE ORGANIZATION MEETS THE PERFORMANCE STANDARDS ADOPTED BY THE DEPARTMENT IN REGULATIONS.

(23) THE DEPARTMENT SHALL INCLUDE A DEFINITION OF MEDICAL NECESSITY IN ITS QUALITY AND ACCESS STANDARDS.

(24) THE DEPARTMENT OR ITS ENROLLMENT CONTRACTOR, TO THE EXTENT FEASIBLE, SHALL HIRE IN ITS MARKETING OR ENROLLMENT PROGRAMS INDIVIDUALS WHO RECEIVE AID UNDER THE AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM ESTABLISHED UNDER TITLE IV, PART A OF THE SOCIAL SECURITY ACT OR THE SUCCESSOR TO THE PROGRAM.

(25) THE DEPARTMENT SHALL DISENROLL AN ENROLLEE WHO IS A CHILD IN STATE-SUPERVISED CARE IF THE CHILD IS PERMANENTLY TRANSFERRED TO AN AREA OUTSIDE OF THE TERRITORY OF THE MANAGED CARE ORGANIZATION.

(26) (I) THERE IS A MARYLAND MEDICAID ADVISORY COMMITTEE.

(II) THE COMMITTEE SHALL CONSIST OF NOT MORE THAN 32 MEMBERS, THE MAJORITY OF WHOM ARE ENROLLEES OR ENROLLEE ADVOCATES, INCLUDING:

1. CURRENT OR FORMER ENROLLEES OR PARENTS OR GUARDIANS OF ENROLLEES;

2. PROVIDERS WHO ARE FAMILIAR WITH THE MEDICAL NEEDS OF LOW-INCOME POPULATION GROUPS AND WHO INCLUDE BOARD-CERTIFIED PHYSICIANS;

3. HOSPITAL REPRESENTATIVES;

4. ADVOCATES FOR THE MEDICAL ASSISTANCE POPULATION, INCLUDING REPRESENTATIVES OF SPECIAL NEEDS POPULATIONS;

5. THREE MEMBERS OF THE SENATE OF MARYLAND, APPOINTED BY THE PRESIDENT OF THE SENATE; AND

6. THREE MEMBERS OF THE MARYLAND HOUSE OF DELEGATES, APPOINTED BY THE SPEAKER OF THE HOUSE.

(III) THE DESIGNEES OF THE FOLLOWING INDIVIDUALS SHALL SERVE AS EX-OFFICIO MEMBERS OF THE COMMITTEE:

1. THE SECRETARY OF THE DEPARTMENT OF HUMAN RESOURCES;

2. THE EXECUTIVE DIRECTOR OF THE HEALTH CARE ACCESS AND COST COMMISSION; AND

3. THE MARYLAND ASSOCIATION OF COUNTY HEALTH OFFICERS.

(IV) IN ADDITION TO ANY DUTIES IMPOSED BY FEDERAL LAW AND REGULATION, THE MARYLAND MEDICAID ADVISORY COMMITTEE SHALL:

1. ADVISE THE SECRETARY ON THE IMPLEMENTATION, OPERATION, AND EVALUATION OF THE MARYLAND MEDICAID MANAGED CARE PROGRAM;

2. REVIEW AND MAKE RECOMMENDATIONS ON THE REGULATIONS DEVELOPED TO IMPLEMENT THE PROGRAM;

3. REVIEW AND MAKE RECOMMENDATIONS ON THE STANDARDS USED IN CONTRACTS BETWEEN THE DEPARTMENT AND MANAGED CARE ORGANIZATIONS;

4. REVIEW AND MAKE RECOMMENDATIONS ON THE DEPARTMENT'S OVERSIGHT OF QUALITY ASSURANCE STANDARDS;

5. REVIEW DATA COLLECTED BY THE DEPARTMENT FROM MANAGED CARE ORGANIZATIONS AND DATA COLLECTED BY THE HEALTH CARE ACCESS AND COST COMMISSION;

6. PROMOTE THE DISSEMINATION OF MANAGED CARE ORGANIZATION PERFORMANCE INFORMATION, INCLUDING LOSS RATIOS, TO ENROLLEES IN A MANNER THAT FACILITATES QUALITY COMPARISONS AND THAT USES LAYMAN'S LANGUAGE;

7. ASSIST THE DEPARTMENT TO EVALUATE THE ENROLLMENT PROCESS;

8. REVIEW REPORTS OF THE OMBUDSMAN PROGRAM; AND

9. PUBLISH AN ANNUAL REPORT.

(V) EXCEPT AS OTHERWISE PROVIDED IN THIS PARAGRAPH, EACH MEMBER OF THE COMMITTEE SHALL BE APPOINTED BY THE SECRETARY AND SHALL SERVE A 4-YEAR TERM.

(VI) IN MAKING APPOINTMENTS TO THE COMMITTEE, THE SECRETARY SHALL PROVIDE FOR CONTINUITY AND ROTATION.

(VII) THE SECRETARY SHALL APPOINT THE CHAIRMAN OF THE COMMITTEE.

(VIII) THE SECRETARY SHALL APPOINT NONVOTING MEMBERS FROM MANAGED CARE ORGANIZATIONS, WHO MAY PARTICIPATE IN COMMITTEE MEETINGS UNLESS THE COMMITTEE MEETS IN CLOSED SESSION, IN ACCORDANCE WITH § 10-508 OF THE STATE GOVERNMENT ARTICLE.

(IX) THE COMMITTEE SHALL DETERMINE THE TIMES AND PLACES OF ITS MEETINGS.

(X) MEMBERS OF THE COMMITTEE:

1. MAY NOT RECEIVE COMPENSATION; BUT

2. ARE ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

(27) THE DEPARTMENT SHALL ADOPT REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SECTION.

15-121.3.

The Department may assign its right of subrogation under §§ 15-120, 15-121.1, and 15-121.2 of this article to a managed care [plan] ORGANIZATION.

**Article - State Finance and Procurement**

11-101.

(n) (1) "Procurement contract" means an agreement in any form entered into by a unit for procurement.

(2) "Procurement contract" does not include:

(i) a collective bargaining agreement with an employee organization;

(ii) an agreement with a contractual employee, as defined in § 1-101(e) of the State Personnel and Pensions Article;

(iii) a Medicaid, Judicare, or similar reimbursement contract for which law sets:

1. user or recipient eligibility; and

2. price payable by the State; or

(iv) a Medicaid contract with a managed care [plan] ORGANIZATION, as defined in § 15-101(d) of the Health - General Articleas to which regulations adopted by the Department establish:

1. recipient eligibility;

2. minimum qualifications for managed care [plans] ORGANIZATIONS; and

3. criteria for enrolling recipients in managed care [plans] ORGANIZATIONS.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Chapter 500 of the Acts of 1995**

[SECTION 2. AND BE IT FURTHER ENACTED, That Section 1 of this Act may not take effect until the beginning of the period covered by a waiver approved by the U.S. Department of Health and Human Services under § 1115 of the SocialSecurity Act and shall be effective only for as long as the period covered under thewaiver.]

[SECTION 3. AND BE IT FURTHER ENACTED, That if Section 1 of this Act takes effect, the Secretary of Health and Mental Hygiene shall report to the Senate Finance Committee and House Environmental Matters Committee of the General Assembly on the effectiveness of this Act and the managed care plans inwhich program recipients are enrolled under this Act. The Secretary shall submit the report to the Committees no later than 1 year after the date Section 1 of this Act takes effect. The report shall include information about the number of program recipientsenrolled in managed care plans, the quality assurance programs for the managed careplans, a comprehensive financial assessment of the management of care of programrecipients in the plans, the scope of program benefits, and the availability of special programs tailored to meet the individual health care needs of program recipients.]

[SECTION 4. AND BE IT FURTHER ENACTED, That Section 1 of this Act may not take effect until the General Assembly gives legislative approval to the proposed plan of the Secretary of Health and Mental Hygiene to implement the program to require enrollment in managed care plans provided under this Act, including thefeasibility of expanding benefits to unserved individuals who are unable to afford health insurance or long-term care, or to other populations.]

SECTION 5. AND BE IT FURTHER ENACTED, That[, subject to Sections 2 and 4 of this Act,] this Act shall take effect July 1, 1995.

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall appear before the Senate Finance Committee and House Environmental Matters Committee of the General Assembly to reporton the implementation of the Secretary's mandatory managed care program on a quarterly basis until 2 years after the Program is first implemented. No later than 1 year after the implementation date of the program, the Secretary shall submit a written report to the Committees which shall include information about the number of Program recipients enrolled in managed care organizations, the quality assurance programs for the managed

care organizations, a comprehensive financial assessment of the management of care of Program recipients in the organizations, the extent to which historic providers have been included in managed care organizations, the scope of Program benefits, and the availability of special programs tailored to meet the individual healthcare needs of Program recipients.

SECTION 4. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall appear before the Senate Finance Committee andthe House Environmental Matters Committee of the General Assembly to report on the Department's plan to incorporate competitive bidding on or before January 1, 1997. The Department may not implement competitive bidding unless specifically authorized to do so by the General Assembly.

SECTION ~~3.~~ 5. AND BE IT FURTHER ENACTED, That no later than 15 days prior to submitting any proposed regulations implementing the Secretary's mandatory managed care program to the ~~AELR Committee for review~~ Joint Committee on Administrative, Executive, and Legislative Review in accordance with Title 10, Subtitle 1 of the State Government Article, the Secretary shall submit the proposed regulations to the Senate Finance Committee and the House Environmental Matters Committee of the General Assembly.

SECTION 6. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall apply for a waiver from the Health Care Financing Administration or take other necessary steps to allow managed care organizations in which enrollment from Medicaid and Medicare recipients exceeds or will exceed 75% of total enrollment to participate in the Program.

SECTION 7. AND BE IT FURTHER ENACTED, That the first annual report required to be submitted by a managed care organization to the Insurance Commissioner in accordance with Article 48A, § 490S shall be submitted on or before March 1, 1998.

SECTION 8. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene and the Insurance Commissioner shall establish a process for the approval of managed care organizations seeking to participate in the Maryland Medical Assistance Managed Care Program that takes no longer than 60 days. The Department shall make available to the public the standards that managed care organizations must comply with at least 60 days before implementation of the Program takeseffect.

SECTION 9. AND BE IT FURTHER ENACTED, That, on or before October 30, 1996, the Department of Health and Mental Hygiene and the Department ofEducation shall, in accordance with § 2-1312 of the State Government Article, report to the Senate Finance Committee and the House Environmental Matters Committee on how the Departments would reimburse local boards of education for services mandated by Individualized Education Plans (IEPs) and Individualized Family ServicePlan (IFSPs) if federal funding for those services is capped or converted to a block grant.

SECTION 10. AND BE IT FURTHER ENACTED, That, on or before December 1, 1996, the Department of Health and Mental Hygiene and the Departmentof Education shall, in accordance with § 2-1312 of the State Government Article, report to the Senate Finance Committee and the House Environmental Matters Committee on the collaboration between managed care organizations and school-based clinics.

SECTION 11. AND BE IT FURTHER ENACTED, That nothing in this Act may be construed to supersede the authority of a local county school board or the Mayor and City Council of Baltimore City, in consultation with parents of children in the school district and parents of students attending a school in which a school-based clinic is based to initiate, discontinue, or manage the operations of a school-based clinic in the school district.

SECTION 12. AND BE IT FURTHER ENACTED, That, until July 1, 1997, a managed care organization that establishes or continues its own delivery system for specialty mental health services may not be required to provide more than 30 days of inpatient psychiatric hospitalization per enrollee per episode of hospitalization.

SECTION ~~4.~~ 13. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~July~~ June 1, 1996.