SENATE BILL 750

Unofficial Copy 1996 Regular Session
J1 6lr2794

CF HB 1051

By: Chairman, Finance Committee (Departmental - Health and Mental Hygiene)
Introduced and read first time: February 15, 1996
Rule 32(b) suspended
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 26, 1996

CHAPTER ____

1 AN ACT concerning

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

3 FOR the purpose of authorizing the Department of Health and Mental Hygiene to
4 provide guaranteed eligibility in the Maryland Medical Assistance Program for a
5 certain period; authorizing the Department to require Program recipients to enroll
6 in managed care organizations; ~~authorizing the Department to prohibit~~ prohibiting,
7 under certain circumstances, managed care organizations from enrolling Program
8 recipients; establishing certain requirements for managed care organizations
9 participating in the Program; ~~authorizing~~ requiring the Department to ~~require~~
10 assure that, under certain circumstances, managed care organizations~~to~~ include
11 providers who have historically served Program recipients; prohibiting a managed
12 care organization from denying or terminating participation on its provider panel
13 under certain circumstances; authorizing the Department to take certain actions;
14 requiring the Department to take certain actions, including making capitation
15 payments in a certain manner; requiring school-based clinics to takecertain actions
16 and provide certain information; requiring a certain delivery systemfor certain
17 mental health care; requiring the Health Resources Planning Commission, in
18 consultation with the Department of Health and Mental Hygiene and the Health
19 Services Cost Review Commission, to conduct a certain study; requiring the Health
20 Resources Planning Commission to submit a certain report by a certain date;
21 requiring the establishment of a Maryland Medicaid Advisory Committee and a
22 Long-Term Managed Care Advisory Committee; requiring the Department to
23 propose certain regulations and adopt certain regulations; defining certain terms;
24 and generally relating to eligibility and managed care organizationsunder the
25 Maryland Medical Assistance Program.

26 BY repealing and reenacting, with amendments,

1 Article - Health - General
2 Section 15-101, 15-102(a), 15-102.1, 15-103(a)and (b), and 15-121.3
3 Annotated Code of Maryland
4 (1994 Replacement Volume and 1995 Supplement)
5 (As enacted by Chapter 500 of the Acts of the General Assembly of 1995)

6 BY repealing and reenacting, with amendments,
7 Article - State Finance and Procurement
8 Section 11-101(n)
9 Annotated Code of Maryland
10 (1995 Replacement Volume and 1995 Supplement)
11 (As enacted by Chapter 500 of the Acts of the General Assembly of 1995)

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

15 BY repealing and reenacting, with amendments,
16 Chapter 500 of the Acts of the General Assembly of 1995
17 Section 5

18 Preamble

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

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

28 WHEREAS, The General Assembly wishes to express its approval of the
29 Secretary's proposal by enacting this legislation which will authorize the Secretary to
30 implement said proposal; and

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

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

37 WHEREAS, Placing Medicaid recipients in managed care organizations and
38 capitating payments to those organizations will enable the State to meet spending caps

1 which may be imposed by the federal government and to slow the rapid growth of the
2 Medicaid Program; and

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

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

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

12 **Article - Health - General**

13 15-101.

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

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

17 (C) "EXCEPTIONAL NEEDS CARE COORDINATOR" MEANS A PERSON
18 EMPLOYED BY THE MANAGED CARE ORGANIZATION TO ASSIST INDIVIDUALS IN
19 SPECIAL NEEDS POPULATIONS TO ACCESS, COORDINATE, AND OBTAIN SERVICES
20 THAT MEET THE INDIVIDUALS' NEEDS.

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

23 (E) (1) "HISTORIC PROVIDER" MEANS A HEALTH CARE PROVIDER, AS
24 DEFINED IN § 19-1501 OF THIS ARTICLE, WHOSE PATIENT PROFILE HAS INCLUDED A
25 SUBSTANTIAL NUMBER, AS IDENTIFIED BY THE DEPARTMENT IN REGULATION, OF
26 PROGRAM RECIPIENTS FOR AT LEAST 5 YEARS.

27 (2) "HISTORIC PROVIDER" INCLUDES, TO THE EXTENT THAT THE
28 PROVIDER'S PATIENT PROFILE MEETS THE REQUIREMENTS OF PARAGRAPH (1) OF
29 THIS SUBSECTION, ACADEMIC HEALTH CENTERS, OUTPATIENT PROGRAMS OWNED
30 OR CONTROLLED BY HOSPITALS, COMMUNITY HEALTH CENTERS, SCHOOL-BASED
31 HEALTH CLINICS, LOCAL HEALTH DEPARTMENTS, AND PHARMACIES.

32 ~~(c)~~ (F) "Managed care [plan] ORGANIZATION" means AN ORGANIZATION
33 OR PROGRAM WHOSE ENROLLMENT DOES NOT EXCEED THE FEDERAL LIMIT OF 75%
34 MEDICAID AND MEDICARE ENROLLEES, UNLESS AND UNTIL THE 75% LIMIT IS
35 REPEALED FROM FEDERAL LAW OR WAIVED BY THE HEALTH CARE FINANCING
36 ADMINISTRATION, AND IS:

37 (1) A certified health maintenance organization; OR

38 (2) A managed care system that is not a health maintenance organization
39 and does not hold a certificate of authority to operate as an insurer but is authorized
40 ~~UNDER FEDERAL LAW OR WAIVER~~ to receive ~~MEDICAID~~ prepaid capitation payments

1 ~~AND IS~~ subject to the regulatory solvency requirements, appropriate forthe risk to be
2 assumed, adopted by the Insurance Commissioner in consultation with theSecretary~~; or~~.

3 ~~(3) A program that provides services to individuals under Title7, Subtitle 3,~~
4 ~~Title 7, Subtitle 7, § 8-204, Title 8, Subtitle 4, Title 10, Subtitle 9, or Title 10, Subtitle 12~~
5 ~~of this article.~~

6 (G) "OMBUDSMAN PROGRAM" MEANS A PROGRAM THAT ASSISTS ENROLLEES
7 IN RESOLVING DISPUTES WITH MANAGED CARE ORGANIZATIONS IN A TIMELY
8 MANNER AND THAT IS RESPONSIBLE, AT A MINIMUM, FOR THE FOLLOWING
9 FUNCTIONS:

10 (1) INVESTIGATING DISPUTES BETWEEN ENROLLEES AND MANAGED
11 CARE ORGANIZATIONS REFERRED BY THE ENROLLEE HOTLINE;

12 (2) REPORTING TO THE DEPARTMENT:

13 (I) THE RESOLUTION OF ALL DISPUTES;

14 (II) A MANAGED CARE ORGANIZATION'S FAILURE TO MEET THE
15 DEPARTMENT'S REQUIREMENTS; AND

16 (III) ANY OTHER INFORMATION SPECIFIED BY THE DEPARTMENT;

17 (3) EDUCATING ENROLLEES ABOUT:

18 (I) THE SERVICES PROVIDED BY THE ENROLLEE'S MANAGED
19 CARE ORGANIZATION; AND

20 (II) THE ENROLLEE'S RIGHTS AND RESPONSIBILITIES IN
21 RECEIVING SERVICES FROM THE MANAGED CARE ORGANIZATION; AND

22 (4) ADVOCATING ON BEHALF OF THE ENROLLEE BEFORE THE
23 MANAGED CARE ORGANIZATION, INCLUDING ASSISTING THE ENROLLEE IN USING
24 THE MANAGED CARE ORGANIZATION'S GRIEVANCE PROCESS.

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

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

28 15-102.

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

32 15-102.1.

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

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

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

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

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

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

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

13 (i) Provider availability throughout the State;

14 (ii) Consumer education;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 15-103.

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

17 (2) The Program:

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

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

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

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

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

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

4 [(vi)] (VII) May include bedside nursing care for eligible Program
5 recipients~~.~~; AND

6 (VIII) SHALL PROVIDE SERVICES IN ACCORDANCE WITH FUNDING
7 RESTRICTIONS INCLUDED IN THE ANNUAL STATE BUDGET BILL.

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

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

13 (2) THE DEPARTMENT MAY CONTRACT DIRECTLY WITH A MANAGED
14 CARE ORGANIZATION TO SERVE PROGRAM RECIPIENTS WITH SPECIAL NEEDS, AS
15 DEFINED BY THE DEPARTMENT, PROVIDED THAT THE MANAGED CARE
16 ORGANIZATION AGREES TO PROVIDE OR TO ARRANGE TO PROVIDE ALL OF THE
17 SERVICES REQUIRED TO BE PROVIDED BY A MANAGED CARE ORGANIZATION.

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

19 (3) IF A MANAGED CARE ORGANIZATION AGREES TO PARTICIPATE IN
20 THE PROGRAM, THE MANAGED CARE ORGANIZATION SHALL:

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

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

26 2. COMPLIES WITH THE QUALITY REQUIREMENTS OF
27 APPLICABLE STATE LICENSURE LAWS AND REGULATIONS;

28 3. COMPLIES WITH PRACTICE GUIDELINES AND PROTOCOLS
29 SPECIFIED BY THE DEPARTMENT;

30 4. PROVIDES FOR AN ENROLLEE GRIEVANCE SYSTEM,
31 INCLUDING AN ENROLLEE HOTLINE;

32 5. PROVIDES FOR ENROLLEE AND PROVIDER SATISFACTION
33 SURVEYS, TO BE TAKEN AT LEAST ANNUALLY;

34 6. PROVIDES FOR A CONSUMER ADVISORY BOARD TO
35 RECEIVE REGULAR INPUT FROM ENROLLEES;

36 7. PROVIDES FOR AN ANNUAL CONSUMER ADVISORY
37 BOARD REPORT TO BE SUBMITTED TO THE SECRETARY; AND

1 8. COMPLIES WITH SPECIFIC QUALITY, ACCESS, DATA, AND
2 PERFORMANCE MEASUREMENTS ADOPTED BY THE DEPARTMENT FOR TREATING
3 ENROLLEES WITH SPECIAL NEEDS;

4 (ii) ~~Collect and submit~~ TO ENABLE THE DEPARTMENT TO MONITOR
5 COMPLIANCE AND PROGRESS OF THE PROGRAM AND TO PROVIDE MANAGED CARE
6 ORGANIZATIONS WITH TIMELY FEEDBACK TO ASSIST THE MANAGED CARE
7 ORGANIZATION IN PROVIDING MORE EFFICIENT AND COST-EFFECTIVE CARE,
8 SUBMIT to the Department: ~~service-specific~~

9 1. SERVICE-SPECIFIC data by service type in a format to be
10 established by the Department; AND

11 2. UTILIZATION AND OUTCOME REPORTS, SUCH AS THE
12 HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS), AS DIRECTED BY
13 THE DEPARTMENT;

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

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

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

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

23 (vi) Provide or assure alcohol and drug abuse treatment for substance
24 abusing pregnant women;

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

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

29 (IX) SUBJECT TO PARAGRAPH (9) OF THIS SUBSECTION, PROVIDE
30 DIAGNOSTIC, EMERGENCY, PREVENTIVE, AND RESTORATIVE DENTAL SERVICES
31 FOR CHILDREN AND FOR ADULTS;

32 ~~(ix)~~ (X) Be accountable AND HOLD ITS SUBCONTRACTORS
33 ACCOUNTABLE for standards established by the Department and, upon failure to meet
34 those standards, be subject to ~~a penalty up to and including revocationof its Medicaid~~
35 ~~managed care contract~~ ONE OR MORE OF THE FOLLOWING PENALTIES:

36 1. FINES;

37 2. SUSPENSION OF FURTHER ENROLLMENTS;

38 3. WITHHOLDING OF ALL OR PART OF THE CAPITATION
39 PAYMENT;

1 4. TERMINATION OF THE CONTRACT;

2 5. DISQUALIFICATION FROM FUTURE PARTICIPATION IN
3 THE PROGRAM; AND

4 6. ANY OTHER PENALTIES THAT MAY BE IMPOSED BY THE
5 DEPARTMENT; ~~and~~

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

10 (XII) PROVIDE OR ARRANGE TO PROVIDE THOSE MENTAL HEALTH
11 SERVICES TRADITIONALLY DELIVERED BY PRIMARY CARE PROVIDERS;

12 (XIII) PROVIDE EXCEPTIONAL NEEDS CARE COORDINATORS TO
13 ASSIST INDIVIDUALS IN SPECIAL NEEDS POPULATIONS, AS DEFINED BY THE
14 DEPARTMENT;

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

19 1. ACCORDING TO STANDARDS SET BY THE DEPARTMENT;
20 AND

21 2. LOCALLY, TO THE EXTENT THE SERVICES ARE
22 AVAILABLE LOCALLY;

23 (XV) MAKE AVAILABLE TO ITS ENROLLEES THE DEPARTMENT'S
24 SUMMARY OF THE QUALITY ASSURANCE PROGRAM REQUIREMENTS;

25 (XVI) SUBMIT TO THE DEPARTMENT AGGREGATE INFORMATION
26 FROM THE QUALITY ASSURANCE PROGRAM, INCLUDING COMPLAINTS AND
27 RESOLUTIONS FROM THE GRIEVANCE SYSTEM AND HOTLINE, AND SATISFACTION
28 SURVEYS;

29 (XVII) INITIALLY PROVIDE, AT A MINIMUM, THE SAME SERVICE
30 LEVEL THAT WAS CONTRACTUALLY REQUIRED TO BE PROVIDED BY MANAGED
31 CARE ORGANIZATIONS TO MEDICAID ENROLLEES AS OF JANUARY 1, 1996;

32 (XVIII) REIMBURSE FOR THE FOLLOWING HEALTH CARE SERVICES
33 PROVIDED, WITHOUT PRIOR APPROVAL FROM THE MANAGED CARE
34 ORGANIZATION, TO AN ENROLLEE IN A HOSPITAL EMERGENCY FACILITY:

35 1. HEALTH CARE SERVICES THAT MEET THE DEFINITION OF
36 EMERGENCY SERVICES IN § 19-701 OF THIS ARTICLE;

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

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

6 4. MEDICALLY NECESSARY SERVICES THAT RELATE TO THE
7 CONDITION PRESENTED AND THAT ARE PROVIDED TO THE ENROLLEE IF THE
8 MANAGED CARE ORGANIZATION FAILS TO PROVIDE 24-HOUR ACCESS TO A
9 PHYSICIAN AS REQUIRED IN THE DEPARTMENT'S REGULATIONS;

10 (XIX) MAINTAIN AS PART OF THE ENROLLEE'S MEDICAL RECORD
11 THE FOLLOWING INFORMATION:

12 1. THE BASIC HEALTH RISK ASSESSMENT CONDUCTED ON
13 ENROLLMENT;

14 2. ANY INFORMATION THE MANAGED CARE
15 ORGANIZATION RECEIVES THAT RESULTS FROM AN ASSESSMENT OF THE
16 ENROLLEE CONDUCTED FOR THE PURPOSE OF ANY EARLY INTERVENTION,
17 EVALUATION, PLANNING, OR CASE MANAGEMENT PROGRAM;

18 3. INFORMATION FROM THE LOCAL DEPARTMENT OF
19 SOCIAL SERVICES REGARDING ANY OTHER SERVICE OR BENEFIT THE ENROLLEE
20 RECEIVES, INCLUDING ASSISTANCE OR BENEFITS UNDER ARTICLE 88A OF THE
21 CODE; AND

22 4. ANY INFORMATION THE MANAGED CARE
23 ORGANIZATION RECEIVES FROM A SCHOOL-BASED CLINIC, A CORE SERVICES
24 AGENCY, A LOCAL HEALTH DEPARTMENT, OR ANY OTHER PERSON THAT HAS
25 PROVIDED HEALTH SERVICES TO THE ENROLLEE; AND

26 (XX) UPON PROVISION OF INFORMATION SPECIFIED BY THE
27 DEPARTMENT UNDER PARAGRAPH (13) OF THIS SUBSECTION, PAY SCHOOL-BASED
28 CLINICS FOR SERVICES PROVIDED TO THE MANAGED CARE ORGANIZATION'S
29 ENROLLEES.

30 (4) A MANAGED CARE ORGANIZATION MAY NOT DENY AN
31 APPLICATION FOR PARTICIPATION OR TERMINATE PARTICIPATION ON ITS
32 PROVIDER PANEL SOLELY ON THE BASIS OF THE LICENSE, CERTIFICATION, OR
33 OTHER AUTHORIZATION OF THE PROVIDER TO PROVIDE SERVICES IF THE
34 MANAGED CARE ORGANIZATION PROVIDES SERVICES WITHIN THE PROVIDER'S
35 LAWFUL SCOPE OF PRACTICE.

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

39 (4) The Secretary shall submit to the Senate Finance Committee and House
40 Environmental Matters Committee of the General Assembly for their review any
41 proposals developed under paragraph (1) of this subsection prior to requesting approval

1 by the U.S. Department of Health and Human Services under § 1115 of theSocial
2 Security Act.]

3 (5) THE DEPARTMENT SHALL:

4 (I) MAINTAIN AN OMBUDSMAN PROGRAM AND A LOCALLY
5 ACCESSIBLE ENROLLEE HOTLINE;

6 (II) PERFORM FOCUSED MEDICAL REVIEWS OF MANAGED CARE
7 ORGANIZATIONS, INCLUDING REVIEWS OF SPECIAL POPULATIONS;

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

10 (IV) ADOPT REGULATIONS RELATING TO APPEALS BY MANAGED
11 CARE ORGANIZATIONS OF PENALTIES IMPOSED BY THE DEPARTMENT, INCLUDING
12 REGULATIONS PROVIDING FOR AN APPEAL TO THE OFFICE OF ADMINISTRATIVE
13 HEARINGS.

14 (6) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (III) OF THIS
15 PARAGRAPH, THE DEPARTMENT SHALL DELEGATE RESPONSIBILITY FOR
16 MAINTAINING THE OMBUDSMAN PROGRAM FOR A COUNTY TO THAT COUNTY'S
17 LOCAL HEALTH DEPARTMENT ON THE REQUEST OF THE LOCAL HEALTH
18 DEPARTMENT.

19 (II) A LOCAL HEALTH DEPARTMENT MAY NOT SUBCONTRACT THE
20 OMBUDSMAN PROGRAM.

21 (III) BEFORE THE DEPARTMENT DELEGATES RESPONSIBILITY TO A
22 LOCAL HEALTH DEPARTMENT TO MAINTAIN THE OMBUDSMAN PROGRAM FOR A
23 COUNTY, A LOCAL HEALTH DEPARTMENT THAT IS ALSO A MEDICAID PROVIDER
24 MUST RECEIVE THE APPROVAL OF THE SECRETARY AND THE LOCAL GOVERNING
25 BODY.

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

28 (7) A MANAGED CARE ORGANIZATION MAY NOT:

29 (I) WITHOUT AUTHORIZATION BY THE DEPARTMENT, ENROLL AN
30 INDIVIDUAL WHO AT THE TIME IS A PROGRAM RECIPIENT; OR

31 (II) HAVE FACE-TO-FACE OR TELEPHONE CONTACT WITH AN
32 INDIVIDUAL WHO AT THE TIME IS A PROGRAM RECIPIENT BEFORE THE PROGRAM
33 RECIPIENT ENROLLS IN THE MANAGED CARE ORGANIZATION UNLESS:

34 1. AUTHORIZED BY THE DEPARTMENT; OR

35 2. THE PROGRAM RECIPIENT INITIATES CONTACT.

36 (8) THE DEPARTMENT SHALL ESTABLISH A HEALTH RISK ASSESSMENT
37 TO BE ADMINISTERED AT THE TIME OF ENROLLMENT TO ASSURE THAT PERSONS IN
38 NEED OF SPECIAL OR IMMEDIATE HEALTH CARE SERVICES WILL RECEIVE
39 APPROPRIATE CARE ON A TIMELY BASIS.

1 [(5)] ~~(4) (i)~~ (9) The Secretary may exclude specific populations or
2 services from any program developed under paragraph (1) of this subsection.

3 (I) THE SECRETARY MAY EXCLUDE ALL DENTAL PROCEDURES
4 AND SERVICES FROM ANY PROGRAM DEVELOPED UNDER PARAGRAPH (1) OF THIS
5 SUBSECTION.

6 (II) THE SECRETARY MAY ESTABLISH A DENTAL MANAGED CARE
7 PROGRAM FOR ENROLLEES.

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

10 (III) THE SECRETARY MAY ESTABLISH A MANAGED CARE
11 PROGRAM FOR PARTICIPANTS IN THE "PACE" PROJECT.

12 [(6)] ~~(5)~~ (10) For a managed care [plan] ORGANIZATION with which the
13 Secretary contracts to provide services to Program recipients under this subsection, the
14 Secretary ~~may require as a condition of that contract that the managed care [plan]~~
15 ~~ORGANIZATION include~~ SHALL INITIALLY ESTABLISH A MECHANISM TO ASSURE
16 THAT A HISTORIC PROVIDER THAT MEETS THE DEPARTMENT'S QUALITY
17 STANDARDS HAS THE OPPORTUNITY TO CONTINUE TO SERVE PROGRAM
18 RECIPIENTS AS A SUBCONTRACTOR OF AT LEAST ONE MANAGED CARE
19 ORGANIZATION[, to the extent economically feasible, particular providers in providing
20 those services in the following circumstances:

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

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

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

32 (11) THE DEPARTMENT SHALL MAKE CAPITATION PAYMENTS THAT ARE
33 ACTUARIALLY ADJUSTED TO:

34 (I) REFLECT THE RELATIVE RISK ASSUMED, AS DETERMINED BY
35 THE DEPARTMENT; AND

36 (II) ENCOURAGE MANAGED CARE ORGANIZATIONS TO DEVELOP
37 EXPERTISE IN TREATING SPECIAL NEEDS POPULATIONS.

38 (12) (I) A MANAGED CARE ORGANIZATION SHALL REPORT ANNUALLY
39 TO THE DEPARTMENT, AS THE DEPARTMENT PRESCRIBES, THE EXPENSE AND LOSS
40 RATIOS INCURRED BY THE MANAGED CARE ORGANIZATION IN DELIVERING
41 SERVICES TO ENROLLEES.

1 (II) FOR CALENDAR YEAR 1997, IF THE MANAGED CARE
2 ORGANIZATION'S LOSS RATIO IS LESS THAN 80% OR ITS EXPENSE RATIO IS GREATER
3 THAN 20%, THE DEPARTMENT SHALL ADJUST THE PAYMENTS MADE TO THE
4 MANAGED CARE ORGANIZATION, UNLESS THE DEPARTMENT GRANTS A WAIVER
5 FROM THESE REQUIREMENTS.

6 (III) FOR CALENDAR YEAR 1998 AND AFTER, IF THE MANAGED
7 CARE ORGANIZATION'S LOSS RATIO IS LESS THAN 85% OR ITS EXPENSE RATIO IS
8 GREATER THAN 15%, THE DEPARTMENT SHALL ADJUST THE PAYMENTS MADE TO
9 THE MANAGED CARE ORGANIZATION, UNLESS THE DEPARTMENT GRANTS A
10 WAIVER FROM THESE REQUIREMENTS.

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

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

16 (III) A MANAGED CARE ORGANIZATION SHALL REQUIRE A
17 SCHOOL-BASED CLINIC TO PROVIDE CERTAIN INFORMATION, AS SPECIFIED BY THE
18 DEPARTMENT, ABOUT AN ENCOUNTER WITH AN ENROLLEE OF THE MANAGED
19 CARE ORGANIZATION PRIOR TO PAYING THE SCHOOL-BASED CLINIC AT
20 MEDICAID-ESTABLISHED RATES.

21 (IV) A MANAGED CARE ORGANIZATION SHALL MAINTAIN A
22 RECORD OF ALL SERVICES FOR WHICH IT HAS BEEN BILLED THAT HAVE BEEN
23 PROVIDED TO AN ENROLLEE BY A SCHOOL-BASED CLINIC.

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

29 (14) THE DEPARTMENT SHALL ESTABLISH STANDARDS FOR THE TIMELY
30 DELIVERY OF SERVICES TO ENROLLEES.

31 (15) THE DEPARTMENT SHALL ESTABLISH A DELIVERY SYSTEM FOR
32 SPECIALTY MENTAL HEALTH CARE THAT SHALL:

33 (I) BE DESIGNED AND MONITORED BY THE MENTAL HYGIENE
34 ADMINISTRATION, WHICH SHALL ESTABLISH THE PERFORMANCE STANDARDS FOR
35 PROVIDERS IN THE DELIVERY SYSTEM;

36 (II) BE RESPONSIBLE FOR PROVIDING ALL SPECIALTY MENTAL
37 HEALTH SERVICES NEEDED BY ENROLLEES WHOSE MENTAL ILLNESS REQUIRES
38 SPECIALTY CARE;

39 (III) OFFER A BENEFIT PACKAGE THAT IS DESIGNED TO MEET THE
40 NEEDS OF ENROLLEES DESCRIBED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH;

41 (IV) HAVE LINKAGES WITH OTHER PUBLIC SERVICE SYSTEMS;

1 (V) INCLUDE MANAGED CARE ORGANIZATIONS THAT ARE
2 COST-EFFECTIVE AND THAT ENTER INTO AGREEMENTS WITH THE DEPARTMENT TO
3 COMPLY WITH THE PERFORMANCE STANDARDS FOR PROVIDERS IN THE DELIVERY
4 SYSTEM FOR SPECIALTY MENTAL HEALTH SERVICES; AND

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

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

10 (17) (I) THE DEPARTMENT SHALL ADOPT REGULATIONS RELATING TO
11 ENROLLMENT, DISENROLLMENT, AND ENROLLEE APPEALS.

12 (II) THE REGULATIONS SHALL PERMIT AN ENROLLEE TO
13 DISENROLL WITHOUT CAUSE FROM A MANAGED CARE ORGANIZATION IN THE
14 MONTH FOLLOWING THE ANNIVERSARY DATE OF THE ENROLLEE'S ENROLLMENT.

15 (III) AN ENROLLEE MAY DISENROLL FROM A MANAGED CARE
16 ORGANIZATION FOR CAUSE.

17 (18) THE DEPARTMENT OR ITS SUBCONTRACTOR, TO THE EXTENT
18 FEASIBLE IN ITS MARKETING PROGRAM, SHALL HIRE INDIVIDUALS RECEIVING
19 ASSISTANCE UNDER THE PROGRAM OF AID TO FAMILIES WITH DEPENDENT
20 CHILDREN ESTABLISHED UNDER TITLE IV, PART A, OF THE SOCIAL SECURITY ACT.

21 (19) THE SECRETARY SHALL ADOPT REGULATIONS TO IMPLEMENT THE
22 PROVISIONS OF THIS SECTION.

23 (20) (I) THE DEPARTMENT SHALL ESTABLISH THE MARYLAND
24 MEDICAID ADVISORY COMMITTEE, COMPOSED OF NO MORE THAN 25 MEMBERS,
25 THE MAJORITY OF WHOM ARE ENROLLEES OR ENROLLEE ADVOCATES.

26 (II) THE COMMITTEE MEMBERS SHALL INCLUDE:

27 1. CURRENT OR FORMER ENROLLEES OR THE PARENTS OR
28 GUARDIANS OF CURRENT OR FORMER ENROLLEES;

29 2. PROVIDERS WHO ARE FAMILIAR WITH THE MEDICAL
30 NEEDS OF LOW-INCOME POPULATION GROUPS, INCLUDING BOARD-CERTIFIED
31 PHYSICIANS;

32 3. HOSPITAL REPRESENTATIVES;

33 4. ADVOCATES FOR THE MEDICAID POPULATION,
34 INCLUDING REPRESENTATIVES OF SPECIAL NEEDS POPULATIONS;

35 5. THREE MEMBERS OF THE FINANCE COMMITTEE OF THE
36 SENATE OF MARYLAND, APPOINTED BY THE PRESIDENT OF THE SENATE; AND

37 6. THREE MEMBERS OF THE ENVIRONMENTAL MATTERS
38 COMMITTEE OF THE MARYLAND HOUSE OF DELEGATES, APPOINTED BY THE
39 SPEAKER OF THE HOUSE.

1 (III) A DESIGNEE OF EACH OF THE FOLLOWING SHALL SERVE AS AN
2 EX-OFFICIO MEMBER OF THE COMMITTEE:

3 1. THE SECRETARY OF HUMAN RESOURCES;

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

6 3. THE MARYLAND ASSOCIATION OF COUNTY HEALTH
7 OFFICERS.

8 (IV) IN ADDITION TO ANY DUTIES IMPOSED BY FEDERAL LAW AND
9 REGULATION, THE COMMITTEE SHALL:

10 1. ADVISE THE SECRETARY ON THE IMPLEMENTATION,
11 OPERATION, AND EVALUATION OF MANAGED CARE PROGRAMS UNDER THIS
12 SECTION;

13 2. REVIEW AND MAKE RECOMMENDATIONS ON THE
14 REGULATIONS DEVELOPED TO IMPLEMENT MANAGED CARE PROGRAMS UNDER
15 THIS SECTION;

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

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

21 5. REVIEW DATA COLLECTED BY THE DEPARTMENT FROM
22 MANAGED CARE ORGANIZATIONS PARTICIPATING IN THE PROGRAM AND DATA
23 COLLECTED BY THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION;

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

28 7. ASSIST THE DEPARTMENT IN EVALUATING THE
29 ENROLLMENT PROCESS;

30 8. REVIEW REPORTS OF THE OMBUDSMEN; AND

31 9. PUBLISH AND SUBMIT AN ANNUAL REPORT TO THE
32 GOVERNOR AND, SUBJECT TO § 2-1312 OF THE STATE GOVERNMENT ARTICLE, THE
33 GENERAL ASSEMBLY.

34 (V) EXCEPT AS SPECIFIED IN SUBPARAGRAPH (II) AND (III) OF THIS
35 PARAGRAPH, THE MEMBERS OF THE MARYLAND MEDICAID ADVISORY COMMITTEE
36 SHALL BE APPOINTED BY THE SECRETARY AND SERVE FOR A 4-YEAR TERM.

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

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

3 (VIII) THE SECRETARY SHALL APPOINT NON-VOTING MEMBERS
4 FROM MANAGED CARE ORGANIZATIONS WHO MAY PARTICIPATE IN COMMITTEE
5 MEETINGS, UNLESS THE COMMITTEE MEETS IN CLOSED SESSION AS PROVIDED IN §
6 10-508 OF THE STATE GOVERNMENT ARTICLE.

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

9 (X) A MEMBER OF THE COMMITTEE:

10 1. MAY NOT RECEIVE COMPENSATION; BUT

11 2. IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER
12 THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE
13 BUDGET.

14 15-121.3.

15 The Department may assign its right of subrogation under §§ 15-120, 15-121.1, and
16 15-121.2 of this article to a managed care [plan] ORGANIZATION.

17 **Article - State Finance and Procurement**

18 11-101.

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

21 (2) "Procurement contract" does not include:

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

23 (ii) an agreement with a contractual employee, as defined in §
24 1-101(e) of the State Personnel and Pensions Article;

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

27 1. user or recipient eligibility; and

28 2. price payable by the State; or

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

32 1. recipient eligibility;

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

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

1 **Chapter 500 of the Acts of 1995**

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

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

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

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

25 SECTION 2. AND BE IT FURTHER ENACTED, That the Secretary of Health
26 and Mental Hygiene shall appear before the Senate Finance Committee andHouse
27 Environmental Matters Committee of the General Assembly to report on the
28 implementation of the Secretary's mandatory managed care program on a quarterly basis
29 until 2 years after the Program is first implemented. Public testimony shall be permitted
30 following the Secretary's mandatory managed care program quarterly reports. No later
31 than 1 year after the implementation date of the program, the Secretaryshall submit a
32 written report to the Committees which shall include information about the number of
33 Program recipients enrolled in managed care organizations, the quality assurance
34 programs for the managed care organizations, a comprehensive financial assessment of
35 the management of care of Program recipients in the organizations, the scope of Program
36 benefits, ~~and~~ the availability of special programs tailored to meet theindividual health
37 care needs of Program recipients, and the Department's plan to incorporate competitive
38 bidding.

39 SECTION 3. AND BE IT FURTHER ENACTED, That no later than 15 days prior
40 to submitting any proposed regulations implementing the Secretary's mandatory managed
41 care program to the AELR Committee for review, the Secretary shall submit the
42 proposed regulations to the Senate Finance Committee and the House Environmental
43 Matters Committee of the General Assembly.

1 SECTION 4. AND BE IT FURTHER ENACTED, That the Secretary shall apply
2 for a waiver from the Health Care Financing Administration or take suchother steps as
3 are necessary to enroll a managed care organization whose Medicaid and Medicare
4 enrollment exceeds 75% of the organization's total enrollment or will exceed 75% of its
5 total enrollment.

6 SECTION 5. AND BE IT FURTHER ENACTED, That managed care
7 organizations participating in the Maryland Medical Assistance Program shall reimburse
8 hospitals in accordance with rates established by the Health Services Cost Review
9 Commission.

10 SECTION 6. AND BE IT FURTHER ENACTED, That the Department of
11 Health and Mental Hygiene and the Maryland Insurance Administration shall propose
12 regulations establishing solvency requirements for Medicaid managed care organizations
13 no later than July 1, 1996.

14 SECTION 7. AND BE IT FURTHER ENACTED, That the Department of
15 Health and Mental Hygiene and the Maryland Insurance Administration shall establish
16 an approval process that takes no longer than 60 days for organizationsapplying to be
17 Medicaid managed care organizations. The standards and requirements forMedicaid
18 managed care organization applications shall be available to the publicno later than 60
19 days before the program takes effect.

20 SECTION 8. AND BE IT FURTHER ENACTED, That:

21 (a) The Health Resources Planning Commission, in consultation with the
22 Department of Health and Mental Hygiene and the Health Services Cost Review
23 Commission, shall study the existing impact on existing community health centers and
24 other primary care providers of the laws, regulations, the grant of a federal waiver, and
25 other governmental actions that authorize or require the enrollment of Maryland Medical
26 Assistance Program recipients into managed care plans or organizations.

27 (b) The study shall include:

28 (1) an assessment of the current availability and accessibilityof primary care
29 services necessary to serve the Medicaid population and the uninsured, and the ability of
30 education programs in primary care specialties, including medical residences, to provide
31 clinical training sites; and

32 (2) an examination of the utilization and reimbursement levels between
33 managed care organizations and ancillary providers of health care services to determine
34 the impact on access to quality medical care.

35 (c) On or before November 1, 1996, the Health Resources Planning Commission
36 shall submit a report on the results of its investigation and study, together with any
37 resulting policy recommendations, to the Governor, the Secretary of Health and Mental
38 Hygiene, and, subject to § 2-1312 of the State Government Article, the General
39 Assembly.

40 SECTION 9. AND BE IT FURTHER ENACTED, That:

1 (a) (1) The Secretary of Health and Mental Hygiene shall establish a
2 Long-Term Managed Care Advisory Committee, composed of no more than 15 members
3 and including legislators, consumers, health care providers, advocates,and State and local
4 agency representatives, to advise on development of a managed care proposal for the
5 Medicaid long-term care population.

6 (2) The Committee shall hear public testimony and conduct public meetings
7 in each region of the State concerning managed care issues for the continuum of
8 long-term health care services.

9 (3) By November 1, 1996, the Committee shall issue a report to the
10 Secretary with findings and recommendations addressing, at a minimum:

11 (i) the population to be served;

12 (ii) the types of services to be provided;

13 (iii) the mechanisms for providing services;

14 (iv) funding; and

15 (v) implementation issues.

16 (4) By January 1, 1997, the Secretary shall develop and presentto the
17 Governor, and subject to § 2-1312 of the State Government Article, the General
18 Assembly a managed care proposal for the Medicaid long-term care population.

19 (b) (1) Additionally, the Secretary may appoint a Long-Term Managed Care
20 Technical Advisory Group, composed of individuals with technical, as well as
21 programmatic, expertise to develop managed care pilot programs.

22 (2) The pilot programs, in selected regions of the State, may:

23 (i) encourage Medicaid recipients to join managed care plans for
24 long-term care benefits coverage;

25 (ii) blend, to the extent possible, Medicaid and Medicare funds for
26 managed care;

27 (iii) utilize varying eligibility criteria, in light of the continued
28 expansion of the long-term care population; and

29 (iv) utilize innovative methods of long-range financing.

30 (3) Any data and information generated by these pilot programs shall be
31 reviewed by the Long-Term Managed Care Advisory Committee and used in the design
32 of managed care programs for the long-term care population.

33 SECTION 10. AND BE IT FURTHER ENACTED, That the Secretary of Health
34 and Mental Hygiene is authorized to make prepaid payments to a program that provided
35 services to individuals under: Title 7, Subtitle 3; Title 7, Subtitle 7; § 8-204; Title 8,
36 Subtitle 4; Title 10, Subtitle 9; or Title 10, Subtitle 12 of the Health - General Article.

1 SECTION 11. AND BE IT FURTHER ENACTED, That this Act may not be
2 construed to supersede the authority of a local county school board, orin Baltimore City
3 the Mayor and City Council, in consultation with parents of students inthe school district
4 and parents of students attending a school in which a school-based clinic is based, to
5 initiate, discontinue, or manage the operations of a school-based clinic in the school
6 district.

7 SECTION ~~4.~~ 12. AND BE IT FURTHER ENACTED, That this Act shall take
8 effect July 1, 1996.