Unofficial Copy 1997 Regular Session
J1 7lr1925
CF 7lr2022

By: Delegates Hurson, Harrison, Branch, Valderrama, Nathan-Pulliam, Krysiak, Rosenberg, Conroy, Hammen, Morhaim, C. Davis, and Rosapepe
Introduced and read first time: January 31, 1997
Assigned to: Environmental Matters

A BILL ENTITLED

AN ACT concerning

Medical Assistance Program - Managed Care Program - Special Needs Children

FOR the purpose of prohibiting the Secretary of Health and Mental Hygiene from including a certain population in a certain managed care program before a certain date; requiring the Secretary to authorize managed care organizations to provide only for a certain population; defining a certain term; requiring the Secretary to set certain capitation rates for certain managed care organizations in a certain manner; and generally relating to the Medical Assistance Managed Care Program and special needs children.

BY repealing and reenacting, without amendments,
Article - Health - General
Section 15-103(a)
Annotated Code of Maryland
(1994 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-103(b)
Annotated Code of Maryland
(1994 Replacement Volume and 1996 Supplement)

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

Article - Health - General

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, shall provide comprehensive medical and other health care services for indigent individuals or medically indigent individuals or both;

(ii) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all 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 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, 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 State budget, 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;

(vi) May include bedside nursing care for eligible Program recipients; and

(vii) Shall provide services in accordance with funding restrictions included in the annual State budget bill.

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

(b) (1) As permitted by federal law or waiver, the Secretary may establish a program under which Program recipients are required to enroll in managed care organizations.

(2) (i) The benefits required by the program developed under paragraph (1) of this subsection shall be adopted by regulation and shall be equivalent to 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 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) (I) IN THIS PARAGRAPH, "SPECIAL NEEDS CHILDREN" MEANS INDIVIDUALS UNDER THE AGE OF 22, REGARDLESS OF MARITAL STATUS, WHO SUFFER FROM A MODERATE TO SEVERE CHRONIC CONDITION THAT:

1. HAS SIGNIFICANT POTENTIAL OR ACTUAL IMPACT ON HEALTH AND ABILITY TO FUNCTION;

2. REQUIRES SPECIAL HEALTH CARE SERVICES; AND

3. IS EXPECTED TO LAST LONGER THAN 6 MONTHS.

(II) UNTIL JANUARY 1, 1998, THE SECRETARY MAY NOT INCLUDE SPECIAL NEEDS CHILDREN IN THE PROGRAM DEVELOPED UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(III) THE SECRETARY SHALL AUTHORIZE MANAGED CARE ORGANIZATIONS THAT HAVE DEMONSTRATED EXPERIENCE IN SERVING THE SPECIAL NEEDS POPULATION TO PROVIDE ALL THE BENEFITS REQUIRED BY REGULATIONS ADOPTED UNDER PARAGRAPH (2) OF THIS SUBSECTION ONLY FOR SPECIAL NEEDS CHILDREN.

(IV) THE SECRETARY MAY NOT REQUIRE SPECIAL NEEDS CHILDREN TO ENROLL IN A MANAGED CARE ORGANIZATION AUTHORIZED TO PROVIDE ONLY FOR SPECIAL NEEDS CHILDREN.

[(6)] (7) Except for the Program of All-inclusive Care for the Elderly ("PACE"), the Secretary may not include the long-term care population or long-term care services in the program developed under paragraph (1) of this subsection.

[(7)] (8) The program developed under paragraph (1) of this subsection shall ensure that enrollees have access to a pharmacy that:

(i) Is licensed in the State; and

(ii) Is within a reasonable distance from the enrollee's residence.

[(8)] (9) For cause, the Department may disenroll enrollees from a managed care organization and enroll them in another managed care organization.

[(9)] (10) Each managed care 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 laws and regulations;

3. Complies with practice guidelines and protocols specified by the Department;

4. Provides for an enrollee grievance system, including an enrollee hotline;

5. Provides a provider grievance system;

6. Provides for enrollee and provider satisfaction surveys, to be taken at least annually;

7. Provides for a consumer advisory board to receive regular input from enrollees;

8. Provides for an annual consumer advisory board report to be submitted to the Secretary; and

9. Complies with specific quality, access, data, and performance measurements adopted by the Department for treating enrollees with special needs;

(ii) Submit to the Department:

1. Service-specific data by service type in a format to be established by the Department; and

2. Utilization and outcome reports, such as the Health Plan Employer Data and Information Set (HEDIS), as directed by the Department;

(iii) Promote timely access to and continuity of health care services for enrollees;

(iv) Demonstrate organizational capacity to provide special programs, including outreach, case management, and home visiting, tailored to meet the individual needs of all enrollees;

(v) Provide assistance to 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 enrollees on health care prevention and good health habits;

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

(ix) Be accountable and hold its subcontractors accountable for standards established by the Department and, upon failure to meet those standards, be subject to one or more of the following penalties:

1. Fines;

2. Suspension of further enrollments;

3. Withholding of all or part of the capitation payment;

4. Termination of the contract;

5. Disqualification from future participation in the Program; and

6. Any other penalties that may be imposed by the Department;

(x) Subject to applicable federal and State law, include incentives for enrollees to comply with provisions of the managed care organization;

(xi) Provide or arrange to provide primary mental health services;

(xii) 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;

(xiii) Submit to the Department aggregate information from the quality assurance program, including complaints and resolutions from the enrollee and provider grievance systems, the enrollee hotline, and enrollee satisfaction surveys;

(xiv) Maintain as part of the enrollee's medical record the following information:

1. The basic health risk assessment conducted on enrollment;

2. Any information the managed care organization receives that results from an assessment of the enrollee conducted for the purpose of any early intervention, evaluation, planning, or case management program;

3. Information from the local department of social services regarding any other service or benefit the enrollee receives, including assistance or benefits under Article 88A of the Code; and

4. Any information the managed care organization receives from a school-based clinic, a core services agency, a local health department, or any other person that has provided health services to the enrollee; and

(xv) Upon provision of information specified by the Department under paragraph [(19)] (20) of this subsection, pay school-based clinics for services provided to the managed care organization's enrollees.

[(10)] (11) The Department shall adopt regulations that assure that managed care organizations employ appropriate personnel to:

(i) Assure that individuals with special needs obtain needed services; and

(ii) Coordinate those services.

[(11)] (12) (i) A managed care organization shall reimburse a hospital emergency facility and provider for:

1. Health care services that meet the definition of emergency services in § 19-701 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, referred, or otherwise allowed the 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 the enrollee if the managed care organization fails to provide 24-hour access to a physician 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.

[(12)] (13) (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 paragraph [(9)] (10)(i) of this subsection; and

2. Upon request by the Department, provide to the Department evidence of compliance with paragraph [(9)] (10)(i) of this subsection.

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

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

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

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

[(13)] (14) The Department shall:

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

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

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

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

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

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

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

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

[(15)] (16) A managed care organization may not:

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

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

1. Authorized by the Department; or

2. The Program recipient initiates contact.

[(16)] (17) (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.

[(17)] (18) For a managed care organization with which the Secretary contracts to provide services to Program recipients under this subsection, the Secretary shall establish a mechanism to initially assure that each historic provider that meets the Department's quality standards has the opportunity to continue to serve Program recipients as a subcontractor of at least one managed care organization.

[(18)] (19) (i) The Department shall make capitation payments to each managed care organization as provided in this paragraph.

(ii) In consultation with the Insurance Commissioner, the Secretary shall:

1. Set capitation payments at a level that is actuarially adjusted to the benefits provided; and

2. Actuarially adjust the capitation payments to reflect the relative risk assumed by the managed care organization.

(III) FOR EACH MANAGED CARE ORGANIZATION AUTHORIZED TO PROVIDE ONLY FOR CHILDREN WITH SPECIAL NEEDS UNDER PARAGRAPH (6) OF THIS SUBSECTION, THE SECRETARY, IN CONSULTATION WITH THE INSURANCE COMMISSIONER, SHALL SET CAPITATION PAYMENTS AT A LEVEL THAT:

1. IS ACTUARIALLY ADJUSTED TO THE BENEFITS PROVIDED; AND

2. IS EQUAL TO THE GREATER OF CAPITATION PAYMENTS THAT ARE:

A. ACTUARIALLY ADJUSTED TO REFLECT THE RELATIVE RISK ASSUMED BY THE MANAGED CARE ORGANIZATION; OR

B. BASED ON THE HISTORICAL 1996 COSTS OF CARING FOR SPECIAL NEEDS CHILDREN LESS 10%, FOR THE FIRST YEAR OF IMPLEMENTATION.

[(19)] (20) (i) School-based clinics and managed care organizations 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.

[(20)] (21) The Department shall establish standards for the timely delivery of services to enrollees.

[(21)] (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.

[(22)] (23) The Department shall include a definition of medical necessity in its quality and access standards.

[(23)] (24) (i) The Department shall adopt regulations relating to enrollment, disenrollment, and enrollee 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.

[(24)] (25) The Department or its subcontractor, to the extent feasible in its marketing or enrollment programs, shall hire individuals receiving assistance under the program of Aid to Families with Dependent Children established under Title IV, Part A, of the Social Security Act, or the successor to the program.

[(25)] (26) The Department shall disenroll an enrollee who is a child in State-supervised care if the child is transferred to an area outside of the territory of the managed care organization.

[(26)] (27) The Secretary shall adopt regulations to implement the provisions of this section.

[(27)] (28) (i) The Department shall establish the Maryland Medicaid Advisory Committee, composed of no more than 25 members, the majority of whom are enrollees or enrollee advocates.

(ii) The Committee members shall include:

1. Current or former enrollees or the parents or guardians of current or former enrollees;

2. Providers who are familiar with the medical needs of low-income population groups, including board-certified physicians;

3. Hospital representatives;

4. Advocates for the Medicaid population, including representatives of special needs populations;

5. Two members of the Finance Committee 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) A designee of each of the following shall serve as an ex-officio member of the Committee:

1. The Secretary of Human Resources;

2. The Executive Director of the Maryland 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 Committee shall:

1. Advise the Secretary on the implementation, operation, and evaluation of managed care programs under this section;

2. Review and make recommendations on the regulations developed to implement managed care programs under this section;

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 participating in the Program and data collected by the Maryland 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 uses layman's language;

7. Assist the Department in evaluating the enrollment process;

8. Review reports of the ombudsmen; and

9. Publish and submit an annual report to the Governor and, subject to § 2-1312 of the State Government Article, the General Assembly.

(v) Except as specified in subparagraph (ii) and (iii) of this paragraph, the members of the Maryland Medicaid Advisory Committee shall be appointed by the Secretary and serve for 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 as provided in § 10-508 of the State Government Article.

(ix) The Committee shall determine the times and places of its meetings.

(x) A member of the Committee:

1. May not receive compensation; but

2. Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 1997.