
By: Senators Madden, Hoffman, McFadden, and Sfikas

Introduced and read first time: January 31, 1997

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Medical Assistance Program - Managed Care Program - Special Needs Children**

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

10 BY repealing and reenacting, without amendments,
11 Article - Health - General
12 Section 15-103(a)
13 Annotated Code of Maryland
14 (1994 Replacement Volume and 1996 Supplement)

15 BY repealing and reenacting, with amendments,
16 Article - Health - General
17 Section 15-103(b)
18 Annotated Code of Maryland
19 (1994 Replacement Volume and 1996 Supplement)

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

22 **Article - Health - General**

23 15-103.

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

26 (2) The Program:

27 (i) Subject to the limitations of the State budget, shall provide
28 comprehensive medical and other health care services for indigent individuals or
29 medically indigent individuals or both;

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1 (ii) Shall provide, subject to the limitations of the State budget,
2 comprehensive medical and other health care services for all eligible pregnant women
3 and, at a minimum, all children currently under the age of 1 whose family income falls
4 below 185 percent of the poverty level, as permitted by the federal law;

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

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

13 (v) Shall provide, subject to the limitations of the State budget,
14 comprehensive medical care and other health care services for all children born after
15 September 30, 1983 who are at least 6 years of age but are under 19 years of age whose
16 family income falls below 100 percent of the poverty level, as permitted by federal law;

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

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

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

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

26 (2) (i) The benefits required by the program developed under paragraph
27 (1) of this subsection shall be adopted by regulation and shall be equivalent to the benefit
28 level required by the Maryland Medical Assistance Program on January 1, 1996.

29 (ii) Nothing in this paragraph may be construed to prohibit a managed
30 care organization from offering additional benefits, if the managed care organization is
31 not receiving capitation payments based on the provision of the additional benefits.

32 (3) Subject to the limitations of the State budget and as permitted by federal
33 law or waiver, the Program developed under paragraph (1) of this subsection may provide
34 guaranteed eligibility for each enrollee for up to 6 months, unless an enrollee obtains
35 health insurance through another source.

36 (4) (i) The Secretary may exclude specific populations or services from
37 the Program developed under paragraph (1) of this subsection.

38 (ii) For any populations or services excluded under this paragraph, the
39 Secretary may authorize a managed care organization, to provide the services or provide
40 for the population, including authorization of a separate dental managed care

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1 organization or a managed care organization to provide services to Program recipients
2 with special needs.

3 (5) (i) Except for a service excluded by the Secretary under paragraph (4)
4 of this subsection, each managed care organization shall provide all the benefits required
5 by regulations adopted under paragraph (2) of this subsection.

6 (ii) For a population or service excluded by the Secretary under
7 paragraph (4) of this subsection, the Secretary may authorize a managed care
8 organization to provide only for that population or provide only that service.

9 (iii) A managed care organization may subcontract specified required
10 services to a health care provider that is licensed or authorized to provide those services.

11 (6) (I) IN THIS PARAGRAPH, "SPECIAL NEEDS CHILDREN" MEANS
12 INDIVIDUALS UNDER THE AGE OF 22, REGARDLESS OF MARITAL STATUS, WHO
13 SUFFER FROM A MODERATE TO SEVERE CHRONIC CONDITION THAT:

14 1. HAS SIGNIFICANT ACTUAL IMPACT ON HEALTH AND
15 ABILITY TO FUNCTION;

16 2. REQUIRES SPECIAL HEALTH CARE SERVICES; AND

17 3. IS EXPECTED TO LAST LONGER THAN 6 MONTHS.

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

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

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

29 [(6)] (7) Except for the Program of All-inclusive Care for the Elderly
30 ("PACE"), the Secretary may not include the long-term care population or long-term
31 care services in the program developed under paragraph (1) of this subsection.

32 [(7)] (8) The program developed under paragraph (1) of this subsection
33 shall ensure that enrollees have access to a pharmacy that:

34 (i) Is licensed in the State; and

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

36 [(8)] (9) For cause, the Department may disenroll enrollees from a
37 managed care organization and enroll them in another managed care organization.

38 [(9)] (10) Each managed care organization shall:

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1 (i) Have a quality assurance program in effect which is subject to the
2 approval of the Department and which, at a minimum:

3 1. Complies with any health care quality improvement system
4 developed by the Health Care Financing Administration;

5 2. Complies with the quality requirements of applicable State
6 licensure laws and regulations;

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

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

11 5. Provides a provider grievance system;

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

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

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

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

20 (ii) Submit to the Department:

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

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

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

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

30 (v) Provide assistance to enrollees in securing necessary health care
31 services;

32 (vi) Provide or assure alcohol and drug abuse treatment for substance
33 abusing pregnant women and all other enrollees of managed care organizations who
34 require these services;

35 (vii) Educate enrollees on health care prevention and good health
36 habits;

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

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

- 6 1. Fines;
- 7 2. Suspension of further enrollments;
- 8 3. Withholding of all or part of the capitation payment;
- 9 4. Termination of the contract;
- 10 5. Disqualification from future participation in the Program;
- 11 and
- 12 6. Any other penalties that may be imposed by the Department;

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

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

16 (xii) Provide or arrange to provide all Medicaid-covered services
 17 required to comply with State statutes and regulations mandating health and mental
 18 health services for children in State supervised care:

- 19 1. According to standards set by the Department; and
- 20 2. Locally, to the extent the services are available locally;

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

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

- 26 1. The basic health risk assessment conducted on enrollment;
- 27 2. Any information the managed care organization receives that
 28 results from an assessment of the enrollee conducted for the purpose of any early
 29 intervention, evaluation, planning, or case management program;
- 30 3. Information from the local department of social services
 31 regarding any other service or benefit the enrollee receives, including assistance or
 32 benefits under Article 88A of the Code; and
- 33 4. Any information the managed care organization receives
 34 from a school-based clinic, a core services agency, a local health department, or any other
 35 person that has provided health services to the enrollee; and

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

4 [(10)] (11) The Department shall adopt regulations that assure that managed
 5 care organizations employ appropriate personnel to:

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

8 (ii) Coordinate those services.

9 [(11)] (12) (i) A managed care organization shall reimburse a hospital
 10 emergency facility and provider for:

11 1. Health care services that meet the definition of emergency
 12 services in § 19-701 of this article;

13 2. Medical screening services rendered to meet the
 14 requirements of the Federal Emergency Medical Treatment and Active Labor Act;

15 3. Medically necessary services if the managed care
 16 organization authorized, referred, or otherwise allowed the enrollee to use the emergency
 17 facility and the medically necessary services are related to the condition for which the
 18 enrollee was allowed to use the emergency facility; and

19 4. Medically necessary services that relate to the condition
 20 presented and that are provided by the provider in the emergency facility to the enrollee
 21 if the managed care organization fails to provide 24-hour access to a physician as
 22 required by the Department.

23 (ii) A provider may not be required to obtain prior authorization or
 24 approval for payment from a managed care organization in order to obtain
 25 reimbursement under this paragraph.

26 [(12)] (13) (i) Each managed care organization shall notify each enrollee
 27 when the enrollee should obtain an immunization, examination, or other wellness service.

28 (ii) Managed care organizations shall:

29 1. Maintain evidence of compliance with paragraph [(9)]
 30 (10)(i) of this subsection; and

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

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

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

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

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1 (iii) The Department or its enrollment contractor shall administer a
2 health risk assessment developed by the Department to ensure that individuals who need
3 special or immediate health care services will receive the services on a timely basis.

4 (iv) The Department or its enrollment contractor:

5 1. May administer the health risk assessment only after the
6 Program recipient has chosen a managed care organization; and

7 2. Shall forward the results of the health risk assessment to the
8 managed care organization chosen by the Program recipient within 5 business days.

9 [(17)] (18) For a managed care organization with which the Secretary
10 contracts to provide services to Program recipients under this subsection, the Secretary
11 shall establish a mechanism to initially assure that each historic provider that meets the
12 Department's quality standards has the opportunity to continue to serve Program
13 recipients as a subcontractor of at least one managed care organization.

14 [(18)] (19) (i) The Department shall make capitation payments to each
15 managed care organization as provided in this paragraph.

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

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

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

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

26 1. IS ACTUARIALLY ADJUSTED TO THE BENEFITS
27 PROVIDED; AND

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

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

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

34 [(19)] (20) (i) School-based clinics and managed care organizations shall
35 collaborate to provide continuity of care to enrollees.

36 (ii) School-based clinics shall be defined by the Department in
37 consultation with the State Department of Education.

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1 (iii) Each managed care organization shall require a school-based
 2 clinic to provide to the managed care organization certain information, as specified by the
 3 Department, about an encounter with an enrollee of the managed care organization prior
 4 to paying the school-based clinic.

5 (iv) Upon receipt of information specified by the Department, the
 6 managed care organization shall pay, at Medicaid-established rates, school-based clinics
 7 for covered services provided to enrollees of the managed care organization.

8 (v) The Department shall work with managed care organizations and
 9 school-based clinics to develop collaboration standards, guidelines, and a process to
 10 assure that the services provided are covered and medically appropriate and that the
 11 process provides for timely notification among the parties.

12 (vi) Each managed care organization shall maintain records of all
 13 health care services:

- 14 1. Provided to its enrollees by school-based clinics; and
- 15 2. For which the managed care organization has been billed.

16 [(20)] (21) The Department shall establish standards for the timely delivery of
 17 services to enrollees.

18 [(21)] (22) (i) The Department shall establish a delivery system for
 19 specialty mental health services for enrollees of managed care organizations.

20 (ii) The Mental Hygiene Administration shall:

- 21 1. Design and monitor the delivery system;
- 22 2. Establish performance standards for providers in the delivery
 23 system; and
- 24 3. Establish procedures to ensure appropriate and timely
 25 referrals from managed care organizations to the delivery system that include:
 - 26 A. Specification of the diagnoses and conditions eligible for
 27 referral to the delivery system;
 - 28 B. Training and clinical guidance in appropriate use of the
 29 delivery system for managed care organization primary care providers;
 - 30 C. Preauthorization by the utilization review agent of the
 31 delivery system; and
 - 32 D. Penalties for a pattern of improper referrals.

33 (iii) The Department shall collaborate with managed care
 34 organizations to develop standards and guidelines for the provision of specialty mental
 35 health services.

36 (iv) The delivery system shall:

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1 1. Provide all specialty mental health services needed by
2 enrollees;

3 2. For enrollees who are dually-diagnosed, coordinate the
4 provision of substance abuse services provided by the managed care organizations of the
5 enrollees;

6 3. Consist of a network of qualified mental health professionals
7 from all core disciplines;

8 4. Include linkages with other public service systems; and

9 5. Comply with quality assurance, enrollee input, data
10 collection, and other requirements specified by the Department in regulation.

11 (v) The Department may contract with a managed care organization
12 for delivery of specialty mental health services if the managed care organization meets the
13 performance standards adopted by the Department in regulations.

14 [(22)] (23) The Department shall include a definition of medical necessity in
15 its quality and access standards.

16 [(23)] (24) (i) The Department shall adopt regulations relating to
17 enrollment, disenrollment, and enrollee appeals.

18 (ii) An enrollee may disenroll from a managed care organization:

19 1. Without cause in the month following the anniversary date of
20 the enrollee's enrollment; and

21 2. For cause, at any time as determined by the Secretary.

22 [(24)] (25) The Department or its subcontractor, to the extent feasible in its
23 marketing or enrollment programs, shall hire individuals receiving assistance under the
24 program of Aid to Families with Dependent Children established under Title IV, Part A,
25 of the Social Security Act, or the successor to the program.

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

29 [(26)] (27) The Secretary shall adopt regulations to implement the provisions
30 of this section.

31 [(27)] (28) (i) The Department shall establish the Maryland Medicaid
32 Advisory Committee, composed of no more than 25 members, the majority of whom are
33 enrollees or enrollee advocates.

34 (ii) The Committee members shall include:

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

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1 (v) Except as specified in subparagraph (ii) and (iii) of this paragraph,
2 the members of the Maryland Medicaid Advisory Committee shall be appointed by the
3 Secretary and serve for a 4-year term.

4 (vi) In making appointments to the Committee, the Secretary shall
5 provide for continuity and rotation.

6 (vii) The Secretary shall appoint the chairman of the Committee.

7 (viii) The Secretary shall appoint nonvoting members from managed
8 care organizations who may participate in Committee meetings, unless the Committee
9 meets in closed session as provided in § 10-508 of the State Government Article.

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

12 (x) A member of the Committee:

13 1. May not receive compensation; but

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

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