HOUSE BILL 4

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(PRE-FILED)

By: **Delegates Hurson, Taylor, Guns, Busch, Rosenberg, Dewberry, Rawlings, Curran, Vallario, Hixson, Harrison, Menes, Kopp, Arnick, Owings, W. Baker, Barve, Benson, Billings, Bobo, Bonsack, Bozman, Branch, E. Burns, Cadden, Clagett, Conroy, Conway, C. Davis, Dembrow, Doory, Dypski, Finifter, Franchot, Frank, Frush, Fulton, Genn, Goldwater, Gordon, Grosfeld, Hammen, Healey, Hecht, Heller, Howard, Jones, Krysiak, Linton, Love, Malone, Mandel, Marriott, McIntosh, Minnick, Morhaim, Muse, Nathan-Pulliam, Opara, Palumbo, Patterson, Pendergrass, Perry, Petzold, Pitkin, Poole, Proctor, Rudolph, Shriver, Slade, Turner, Valderrama, Weir, Wood, and Workman**

Requested: November 15, 1997
Introduced and read first time: January 14, 1998
Assigned to: Environmental Matters and Economic Matters

A BILL ENTITLED

AN ACT concerning

Children and Families First Health Care Act of 1998

FOR the purpose of establishing the Children and Families Health Care Program under which certain individuals who meet certain family income standards would be eligible for Maryland Medical Assistance Program benefits; requiring the Secretary of Health and Mental Hygiene to provide presumptive eligibility to certain individuals under certain circumstances; transferring responsibility for the enrollment of eligible individuals into the Maryland Medical Assistance Program from the Department of Health and Mental Hygiene to the Maryland Health Care Foundation; requiring the Foundation to establish a certain school-based enrollment program; requiring the Foundation to develop certain outreach and enrollment options; requiring the Foundation to develop certain options and strategies through the use of certain demonstration projects for the purpose of expanding the availability of health insurance coverage to certain individuals who meet certain family income standards; requiring the Foundation to submit an annual report to certain persons in regard to the demonstration projects; requiring the Secretary to seek a certain waiver; requiring Secretary to solicit invitations from managed care organizations to participate in the managed care program and award participation on a competitive basis; requiring managed care organizations participating in the managed care program to provide information to the Department on the cost of premiums for a certain health benefit package that would cover a family with dependents; requiring insurers and nonprofit health service plans that issue or deliver group or blanket health insurance policies to provide enrollment information for the Children and Families Health Care Program; requiring the

Department and the Foundation to enter into a certain memorandum of understanding; requiring certain funds to be transferred to a certain account for a certain purpose; requiring the Foundation to submit a certain report by a certain date; providing the construction of certain provisions of this Act; providing for the termination of a certain provision of this Act; defining certain terms; and generally relating to establishing the Children and Families Health Care Program.

BY renumbering
Article - Health - General
Section 15-301 and the subtitle "Subtitle 3. Evaluation and Planning Services"
to be Section 15-501 and the subtitle "Subtitle 5. Evaluation and Planning Services"
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-101 and 15-103
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY adding to
Article - Health - General
Section 15-301 through 15-304, inclusive, to be under the new subtitle "Subtitle 3. Children and Families Health Care Program"
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 20-506
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY adding to
Article - Insurance
Section 15-124
Annotated Code of Maryland
(1997 Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 15-301 and the subtitle "Subtitle 3. Evaluation and Planning Services" of Article - Health - General of the Annotated Code of Maryland

be renumbered to be Section(s) 15-501 and the subtitle "Subtitle 5. Evaluation and Planning Services".

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

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.

(c) "Facility" means a hospital or nursing facility including an intermediate care facility, skilled nursing facility, comprehensive care facility, or extended care facility.

(D) "FOUNDATION" MEANS THE MARYLAND HEALTH CARE FOUNDATION ESTABLISHED UNDER TITLE 20, SUBTITLE 5 OF THIS ARTICLE.

(E) "HEALTH MAINTENANCE ORGANIZATION" HAS THE MEANING STATED IN § 19-701 OF THIS ARTICLE.

[(d)] (F) (1) "Historic provider" means a health care provider, as defined in § 19-1501 of this article who, on or before June 30, 1995, had a demonstrated history of providing services to program recipients, as defined by the Department in regulations.

(2) "Historic provider", to the extent the provider meets the requirements in paragraph (1) of this subsection, shall 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 hospice, as defined in Title 19, Subtitle 9 of this article;

(vi) A pharmacy; and

(vii) Any other historic provider designated in accordance with regulations adopted by the Department.

[(e)] (G) "Managed care organization" means:

(1) A certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments; 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 requirements of § 15-102.4 of this title.

[(f)] (H) "Ombudsman program" means a program that assists enrollees in resolving disputes with managed care organizations in a timely manner and that is responsible, at a minimum, for the following functions:

(1) Investigating disputes between enrollees and managed care organizations referred by the enrollee hotline;

(2) Reporting to the Department:

(i) The resolution of all disputes;

(ii) A managed care organization's failure to meet the Department's requirements; and

(iii) Any other information specified by the Department;

(3) Educating enrollees about:

(i) The services provided by the enrollee's managed care organization; and

(ii) The enrollee's rights and responsibilities in receiving services from the managed care organization; and

(4) Advocating on behalf of the enrollee before the managed care organization, including assisting the enrollee in using the managed care organization's grievance process.

[(g)] (I) "Primary mental health services" means the clinical evaluation and assessment of services needed by an individual and the provision of services or referral for additional services as deemed medically appropriate by a primary care provider.

[(h)] (J) "Program" means the Maryland Medical Assistance Program.

[(i)] (K) "Program recipient" means an individual who receives benefits under the Program.

[(j)] (L) "Specialty mental health services" means any mental health services other than primary mental health services.

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) Shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services for all legal immigrants who meet Program eligibility standards and who arrived in the United States before August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act, as permitted by federal law;

(vii) Shall provide, subject to the limitations of the State budget and any other requirements imposed by the State, comprehensive medical care and other health care services for all legal immigrant children under the age of 18 years and pregnant women who meet Program eligibility standards and who arrived in the United States on or after August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

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

(ix) 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.

(4) (I) TO THE EXTENT ALLOWED UNDER FEDERAL LAW AND REGULATIONS, THE SECRETARY SHALL IMPLEMENT PRESUMPTIVE ELIGIBILITY FOR ANY CHILD WHO APPLIES FOR THE PROGRAM UNDER THIS SECTION.

(II) THE SECRETARY SHALL ADOPT REGULATIONS TO ESTABLISH STANDARDS AND PROCEDURES FOR THE DESIGNATION OF ORGANIZATIONS AS QUALIFIED ENTITIES TO GRANT PRESUMPTIVE ELIGIBILITY.

(III) IN DEVELOPING THE REGULATIONS REQUIRED UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE SECRETARY SHALL ENSURE THE REPRESENTATION OF STATEWIDE AND LOCAL ORGANIZATIONS THAT PROVIDE SERVICES TO CHILDREN OF ALL AGES IN EACH REGION OF THE STATE.

(IV) THE SECRETARY SHALL PROVIDE QUALIFIED ENTITIES:

1. WITH FORMS THAT ARE NECESSARY FOR PARENTS, GUARDIANS, AND OTHER INDIVIDUALS TO SUBMIT APPLICATIONS TO THE PROGRAM ON BEHALF OF A CHILD; AND

2. INFORMATION ON HOW TO ASSIST PARENTS, GUARDIANS, AND OTHER INDIVIDUALS IN COMPLETING AND FILING SUCH APPLICATIONS.

(b) (1) (I) 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.

(II) THE DEPARTMENT SHALL SOLICIT INVITATIONS FOR BIDS AND AWARD CONTRACTS WITH MANAGED CARE ORGANIZATIONS TO PROVIDE THE BENEFITS REQUIRED UNDER THE PROGRAM ESTABLISHED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH IN ACCORDANCE WITH THE PROVISIONS OF DIVISION II OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(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) Subject to the limitations of the State budget and as permitted by federal law or waiver, the Department shall provide reimbursement for medically necessary and appropriate inpatient, intermediate care, and halfway house substance abuse treatment services for substance abusing enrollees 21 years of age or older who are recipients of temporary cash assistance under the Family Investment Program.

(iii) Each managed care organization participating in the program developed under paragraph (1) of this subsection shall provide or arrange for the provision of the benefits described in subparagraph (ii) of this paragraph.

(iv) 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) Except for the Program of All-inclusive Care for the Elderly ("PACE") Program, 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) 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) For cause, the Department may disenroll enrollees from a managed care organization and enroll them in another managed care organization.

(9) 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) of this subsection, pay school-based clinics for services provided to the managed care organization's enrollees.

(10) 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) (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) (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)(i) of this subsection; and

2. Upon request by the Department, provide to the Department evidence of compliance with paragraph (9)(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) The Department shall:

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

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

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

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

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

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

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

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

(15) A managed care organization may not:

(i) Without authorization by the Department OR THE FOUNDATION, 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 THE FOUNDATION; or

2. The Program recipient initiates contact.

(16) (i) [The Department] AS PROVIDED IN § 15-302 OF THIS TITLE, THE FOUNDATION shall be responsible for enrolling Program recipients into managed care organizations.

(ii) The [Department] FOUNDATION may contract with an entity to perform the enrollment function.

(iii) The [Department] FOUNDATION 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] FOUNDATION 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) 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) (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.

(19) (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) The Department shall establish standards for the timely delivery of services to enrollees.

(21) (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) The Department shall include a definition of medical necessity in its quality and access standards.

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

[(27)] (26) (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 § 2-1246 of the State Government Article, the General Assembly.

(v) Except as specified in subparagraphs (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.

(c) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Certified nurse practitioner" means a registered nurse who is licensed in this State, has completed a nurse practitioner program approved by the State Board of Nursing, and has passed an examination approved by that Board.

(iii) "Nurse anesthetist" means a registered nurse who is:

1. Certified under the Health Occupations Article to practice nurse anesthesia; and

2. Certified by the Council on Certification or the Council on Recertification of Nurse Anesthetists.

(iv) "Nurse midwife" means a registered nurse who is licensed in this State and has been certified by the American College of Nurse-Midwives as a nurse midwife.

(v) "Optometrist" has the meaning stated in § 11-101 of the Health Occupations Article.

(2) The Secretary may contract for the provision of care under the Program to eligible Program recipients.

(3) The Secretary may contract with insurance companies or nonprofit health service plans or with individuals, associations, partnerships, incorporated or unincorporated groups of physicians, chiropractors, dentists, podiatrists, optometrists, pharmacists, hospitals, nursing homes, nurses, including nurse anesthetists, nurse midwives and certified nurse practitioners, opticians, and other health practitioners who are licensed or certified in this State and perform services on the prescription or referral of a physician.

(4) For the purposes of this section, the nurse midwife need not be under the supervision of a physician.

(5) Except as otherwise provided by law, a contract that the Secretary makes under this subsection shall continue unless terminated under the terms of the contract by the Program or by the provider.

(d) The Secretary shall apply for a waiver from the Health Care Financing Administration of the U.S. Department of Health and Human Services or take any other steps necessary to obtain federal reimbursement for providing program services to any minor who had qualified, and subsequently lost eligibility, as disabled under the federal Supplemental Security Income (SSI) Program before August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act.

(E) EACH MANAGED CARE ORGANIZATION UNDER CONTRACT WITH THE DEPARTMENT TO PROVIDE SERVICES TO ENROLLEES UNDER SUBSECTION (B) OF THIS SECTION SHALL SUBMIT TO THE DEPARTMENT INFORMATION ON THE COST OF PREMIUMS TO COVER A FAMILY WITH DEPENDENTS UNDER A HEALTH BENEFIT PACKAGE THAT:

(1) SATISFIES THE REQUIREMENTS UNDER FEDERAL LAW OR REGULATION FOR PURPOSES OF RECEIVING FEDERAL REIMBURSEMENT; AND

(2) IS SUBSTANTIALLY EQUIVALENT TO THE BENEFITS OFFERED IN THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN ADOPTED BY THE HEALTH CARE ACCESS AND COST COMMISSION UNDER TITLE 19, SUBTITLE 15 OF THIS ARTICLE AND § 15-1207 OF THE INSURANCE ARTICLE.

SUBTITLE 3. CHILDREN AND FAMILIES HEALTH CARE PROGRAM.

15-301.

(A) THE DEPARTMENT SHALL ESTABLISH THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM.

(B) THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM SHALL PROVIDE, SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND ANY OTHER REQUIREMENTS IMPOSED BY THE STATE AND AS PERMITTED BY FEDERAL LAW OR WAIVER, COMPREHENSIVE MEDICAL CARE AND OTHER HEALTH CARE SERVICES TO CHILDREN FROM BIRTH TO THE AGE OF 19 YEARS OF AGE WHOSE FAMILY INCOME IS AT OR BELOW 185% OF THE FEDERAL POVERTY LEVEL.

(C) SUBJECT TO FEDERAL LAW OR WAIVER, TO THE EXTENT POSSIBLE AND IT IS COST EFFECTIVE, THE DEPARTMENT SHALL ENDEAVOR TO SERVE THOSE PROGRAM RECIPIENTS, WHO QUALIFY FOR THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM UNDER THIS SECTION, THROUGH THE USE OF THE HEALTH INSURANCE PURCHASING CREDIT MECHANISM ESTABLISHED UNDER § 15-304 OF THIS SUBTITLE IF THE PROGRAM RECIPIENT IS A MEMBER OF A FAMILY THAT HAS ACCESS TO AFFORDABLE AND COMPREHENSIVE EMPLOYER-BASED DEPENDENT COVERAGE.

15-302.

(A) (1) THE FOUNDATION SHALL BE RESPONSIBLE FOR ENROLLING PROGRAM RECIPIENTS INTO MANAGED CARE ORGANIZATIONS UNDER THE PROGRAM ESTABLISHED UNDER § 15-103 OF THIS TITLE AND THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(2) THE FOUNDATION MAY CONTRACT WITH AN ENTITY TO PERFORM ANY PART OR ALL OF ITS ENROLLMENT RESPONSIBILITIES UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(3) THE FOUNDATION OR ITS ENROLLMENT CONTRACTOR, TO THE EXTENT FEASIBLE IN ITS MARKETING, OUTREACH, AND ENROLLMENT PROGRAMS, SHALL HIRE INDIVIDUALS RECEIVING ASSISTANCE UNDER THE FAMILY INVESTMENT PROGRAM ESTABLISHED UNDER ARTICLE 88A OF THE CODE.

(B) (1) FOR PURPOSES OF ENROLLING ELIGIBLE CHILDREN INTO THE PROGRAM AND IN MANAGED CARE ORGANIZATIONS IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION, THE FOUNDATION SHALL DEVELOP AND IMPLEMENT A SCHOOL-BASED ENROLLMENT PROGRAM.

(2) AS APPROPRIATE TO CARRY OUT ITS RESPONSIBILITIES UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE FOUNDATION MAY ENTER INTO CONTRACTS WITH COUNTY BOARDS OF EDUCATION TO PROVIDE ON SITE AT PUBLIC SCHOOLS INFORMATION ABOUT THE PROGRAM AND ENROLL ELIGIBLE PROGRAM RECIPIENTS IN MANAGED CARE ORGANIZATIONS UNDER THE PROGRAM

ESTABLISHED UNDER § 15-103 OF THIS TITLE AND THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(C) (1) THE FOUNDATION SHALL MONITOR APPLICATIONS TO DETERMINE WHETHER EMPLOYERS AND EMPLOYEES HAVE DROPPED EMPLOYER-BASED HEALTH INSURANCE COVERAGE WHICH INCLUDED AN OPTION FOR DEPENDENT COVERAGE IN ORDER TO PARTICIPATE IN THE PROGRAM.

(2) THE FOUNDATION IN PARTICULAR SHALL REVIEW APPLICATIONS OF INDIVIDUALS WHO QUALIFIED FOR PROGRAM BENEFITS UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(3) AN APPLICATION MAY BE DISAPPROVED IF IT IS DETERMINED THAT A CHILD TO BE COVERED UNDER THE PROGRAM FOR WHOM THE APPLICATION WAS SUBMITTED WAS COVERED BY EMPLOYER-BASED HEALTH INSURANCE WHICH WAS VOLUNTARILY TERMINATED WITHIN 3 MONTHS PRECEDING THE DATE OF THE APPLICATION.

15-303.

(A) (1) IN ADDITION TO THE SCHOOL-BASED ENROLLMENT PROGRAM ESTABLISHED UNDER § 15-302 OF THIS SUBTITLE, THE FOUNDATION, IN CONSULTATION WITH THE MARYLAND MEDICAID ADVISORY COMMITTEE ESTABLISHED UNDER § 15-103(B) OF THIS TITLE, SHALL DEVELOP MECHANISMS FOR OUTREACH FOR THE PROGRAM WITH A SPECIAL EMPHASIS ON IDENTIFYING CHILDREN WHO MAY BE ELIGIBLE FOR PROGRAM BENEFITS UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(2) FROM THE MECHANISMS TO BE DEVELOPED FOR OUTREACH UNDER PARAGRAPH (1) OF THIS SUBSECTION, ONE MECHANISM SHALL INCLUDE THE DEVELOPMENT AND DISSEMINATION OF MAIL-IN APPLICATIONS AND APPROPRIATE OUTREACH MATERIALS THROUGH COMMUNITY-BASED ORGANIZATIONS, THE OFFICE OF THE STATE COMPTROLLER, THE DEPARTMENTS OF HUMAN RESOURCES AND HEALTH AND MENTAL HYGIENE, COUNTY BOARDS OF EDUCATION, AND ANY OTHER APPROPRIATE STATE AGENCY OR UNIT THE FOUNDATION CONSIDERS APPROPRIATE.

(B) FOR PURPOSES OF THIS SECTION, "COMMUNITY-BASED ORGANIZATION" INCLUDES DAY CARE CENTERS, SCHOOLS, SCHOOL-BASED HEALTH CLINICS, COMMUNITY-BASED DIAGNOSTIC AND TREATMENT CENTERS, AND HOSPITALS.

20-506.

(a) The Foundation shall:

(1) Solicit and accept any gift, grant, legacy, or endowment of money, including in-kind services, from the federal government, State government, local government, or any private source in furtherance of the Foundation;

(2) Provide grants to programs that:

(i) Promote public awareness of the need to provide more timely and cost-effective care for uninsured Marylanders;

(ii) Expand access to health care services for uninsured individuals; or

(iii) Provide or subsidize health insurance coverage for uninsured individuals;

(3) DEVELOP DEMONSTRATION PROJECTS FOR THE PURPOSE OF EXPANDING THE AVAILABILITY OF HEALTH INSURANCE TO UNINSURED CHILDREN AND FAMILIES IN ACCORDANCE WITH § 15-304 OF THIS ARTICLE;

[(3)] (4) Develop programs for sponsorship by corporate and business organizations or private individuals;

[(4)] (5) Develop criteria for awarding grants to health care delivery programs, insurance coverage programs, or corporate sponsorship programs;

[(5)] (6) Develop criteria for prioritizing programs to be supported;

[(6)] (7) Develop criteria for evaluating the effectiveness of programs receiving grants;

(8) CARRY OUT ITS RESPONSIBILITIES UNDER § 15-103 OF THIS ARTICLE AND TITLE 15, SUBTITLE 3 OF THIS ARTICLE;

[(7)] (9) Make, execute, and enter into any contract or other legal instrument;

[(8)] (10) Receive appropriations as provided in the State budget;

[(9)] (11) Lease and maintain an office at a place within the State that the Foundation designates;

[(10)] (12) Adopt bylaws for the regulation of its affairs and the conduct of its business;

[(11)] (13) Take any other action necessary to carry out the purposes of the Foundation; and

[(12)] (14) Report annually to the Governor and, subject to § 2-1246 of the State Government Article, to the General Assembly, on its activities during the preceding year, including an evaluation of the effectiveness of funded programs, together with any recommendations or requests deemed appropriate to further the purposes of the Foundation.

(b) The Foundation may sue and be sued, but only to enforce contractual or similar agreements with the Foundation.

Article - Insurance

15-124.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "BLANKET HEALTH INSURANCE" HAS THE MEANING STATED IN § 15-301 OF THIS TITLE.

(3) "GROUP HEALTH INSURANCE" HAS THE MEANING STATED IN § 15-301 OF THIS TITLE.

(B) THIS SECTION APPLIES TO INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT ISSUE OR DELIVER GROUP HEALTH INSURANCE POLICIES OR BLANKET HEALTH INSURANCE POLICIES IN THE STATE.

(C) AN ENTITY SUBJECT TO THIS SECTION WHEN ISSUING OR RENEWING A GROUP OR BLANKET HEALTH INSURANCE POLICY WITH AN EMPLOYER THAT DOES NOT INCLUDE DEPENDENT COVERAGE SHALL PROVIDE ENROLLMENT INFORMATION TO INSURED EMPLOYEES REGARDING THE METHODS OF ENROLLING ANY DEPENDENT OF AN INSURED EMPLOYEE IN THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THE HEALTH - GENERAL ARTICLE.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

15-304.

(A) THE FOUNDATION SHALL DEVELOP A VARIETY OF OPTIONS AND STRATEGIES FOR EXPANDING THE AVAILABILITY OF HEALTH INSURANCE COVERAGE TO CHILDREN AND THEIR FAMILIES WHOSE FAMILY INCOME EXCEEDS 185% OF THE FEDERAL POVERTY LEVEL AND DOES NOT EXCEED 200% OF THE FEDERAL POVERTY LEVEL AS PART OF THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(B) (1) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND FEDERAL LAW OR WAIVER, THE FOUNDATION, IN ACCORDANCE WITH A MEMORANDUM OF UNDERSTANDING WITH THE DEPARTMENT, WHICH OUTLINES THE DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT AND THE FOUNDATION, SHALL IMPLEMENT THESE OPTIONS AND STRATEGIES AS DEMONSTRATION PROJECTS.

(2) THE DEMONSTRATION PROJECTS SHALL INCLUDE:

(I) AN INSURANCE COVERAGE PROGRAM THAT PROVIDES SUBSIDIES TO ELIGIBLE FAMILIES FOR THE PURPOSE OF ASSISTING FAMILIES TO OBTAIN OR MAINTAIN EMPLOYER-BASED HEALTH INSURANCE COVERAGE;

(II) A PROGRAM THAT PROVIDES HEALTH INSURANCE PURCHASING CREDITS TO ELIGIBLE PROGRAM RECIPIENTS WHO ARE MEMBERS OF FAMILIES THAT HAVE ACCESS TO AFFORDABLE AND COMPREHENSIVE EMPLOYER-BASED DEPENDENT COVERAGE;

(III) A HEALTH CARE DELIVERY PROGRAM THAT PROVIDES VOUCHERS TO ELIGIBLE UNINSURED FAMILIES TO UTILIZE HEALTH CARE CLINICS IN RURAL SETTINGS IN THE STATE; AND

(IV) A PROGRAM THAT PROVIDES DIRECT GRANTS TO HEALTH CARE PROVIDERS THAT DEMONSTRATE THAT THEY PROVIDE HIGH VOLUME HEALTH CARE SERVICES TO UNINSURED CHILDREN IN URBAN AREAS IN THE STATE.

(C) THE DEPARTMENT SHALL APPLY FOR A WAIVER FROM THE HEALTH CARE FINANCING ADMINISTRATION OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OR TAKE WHATEVER STEPS NECESSARY TO OBTAIN FEDERAL REIMBURSEMENT TO FUND ANY DEMONSTRATION PROJECT DEVELOPED BY THE FOUNDATION UNDER SUBSECTION (B) OF THIS SECTION THAT WOULD EXPAND HEALTH INSURANCE COVERAGE TO FAMILIES WITH DEPENDENT CHILDREN UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(D) BEGINNING JULY 1, 1999, AND EACH JULY 1 THEREAFTER, THE FOUNDATION SHALL SUBMIT A REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY ON THE DEMONSTRATION PROJECTS DEVELOPED UNDER THIS SECTION IN REGARD TO THEIR EFFECTIVENESS IN EXPANDING THE AVAILABILITY OF HEALTH INSURANCE COVERAGE FOR CHILDREN AND THEIR FAMILIES.

SECTION 4. AND BE IT FURTHER ENACTED, That the Department and the Maryland Health Care Foundation shall enter into a memorandum of understanding with respect to the enrollment of eligible individuals into the Maryland Medical Assistance Program established under Title 15, Subtitle 1 of the Health - General Article and enrollment of Maryland Medical Assistance Program recipients into managed care organizations under the managed care program established under § 15-103(b) of the Health - General Article and the Children and Families Health Care Program established under § 15-301 of the Health - General Article.

SECTION 5. AND BE IT FURTHER ENACTED, That, prior to the abrogation of Section 3 of this Act, as provided in Section 8 of this Act, the Maryland Health Care Foundation shall:

(a) study the effectiveness of the demonstration projects developed under § 15-304 of the Health - General Article in regard to expanding and broadening the availability of health insurance coverage to children and their families; and

(b) on or before July 1, 2003, submit a report to the Governor and, subject to § 2-1246 of the State Government Article, to the General Assembly, with recommendations as to whether § 15-304 of the Health - General Article should be amended or allowed to abrogate.

SECTION 6. AND BE IT FURTHER ENACTED, That, at the end of each fiscal year, any excess funds that remain from the General Fund appropriation in the annual budget to the Department of Health and Mental Hygiene to provide benefits to eligible individuals under the Children and Families Health Care Program established under § 15-301 of the Health - General Article shall be transferred to a dedicated purpose account to be used by the Maryland Health Care Foundation to fund demonstration projects developed by the Maryland Health Care Foundation under § 15-304 of the Health - General Article.

SECTION 7. AND BE IT FURTHER ENACTED, That the transfer of the enrollment function under § 15-103(b) of the Health - General Article of this Act from the Department of Health and Mental Hygiene to the Maryland Health Care Foundation under this Act may not impair any contract that the Department of Health and Mental Hygiene has in effect with an entity to enroll Medical Assistance Program recipients in managed care organizations prior to the enactment of this Act. The provisions of any such contract shall continue in effect with the Maryland Health Care Foundation under the same terms and conditions as with the Department of Health and Mental Hygiene until its termination.

SECTION 8. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take effect July 1, 1998. It shall remain effective for a period of 6 years and, at the end of June 30, 2004, with no further action required by the General Assembly, Section 3 shall be abrogated and of no further force and effect.

SECTION 9. AND BE IT FURTHER ENACTED, That, except as provided in Section 8 of this Act, this Act shall take effect July 1, 1998.