SENATE BILL 486

Unofficial Copy 1999 Regular Session
J4 9lr1878
CF 9lr1877

By: **Senator Exum**
Introduced and read first time: February 5, 1999
Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Medical Assistance - Program Recipients - Continuity of Care**

3 FOR the purpose of requiring the Department of Health and Mental Hygiene to
4 establish certain mechanisms for identifying the primary care provider of a
5 recipient of medical assistance and assigning the recipient to that provider;
6 requiring a managed care organization, under certain circumstances, to assign a
7 recipient of medical assistance to the recipient's primary care provider as
8 identified by the Department during the enrollment process; allowing an
9 enrollee in the Maryland Medical Assistance Program to disenroll under certain
10 circumstances; and generally relating to the Maryland Medical Assistance
11 Program and continuity of care for program recipients.

12 BY repealing and reenacting, with amendments,
13 Article - Health - General
14 Section 15-102.1, 15-102.5, and 15-103(b)(23)
15 Annotated Code of Maryland
16 (1994 Replacement Volume and 1998 Supplement)

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

19 **Article - Health - General**

20 15-102.1.

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

24 (b) The Department shall, to the extent permitted, subject to the limitations of
25 the State budget:

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

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

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

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

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

10 (i) Provider availability throughout the State;

11 (ii) Consumer education;

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

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

17 (6) ESTABLISH MECHANISMS FOR IDENTIFYING A PROGRAM
18 RECIPIENT'S PRIMARY CARE PROVIDER AT THE TIME OF ENROLLMENT AND, IF THE
19 PROVIDER HAS A CONTRACT WITH A MANAGED CARE ORGANIZATION AND THE
20 RECIPIENT DESIRES TO CONTINUE CARE WITH THE PROVIDER, MECHANISMS FOR
21 ASSIGNING THE PROGRAM RECIPIENT TO THE PROVIDER;

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

24 [(7)] (8) Require health care providers who participate in the Program to
25 provide access to Program recipients on a nondiscriminatory basis in accordance with
26 State and federal law;

27 [(8)] (9) Seek to provide appropriate levels of reimbursement for
28 providers to encourage greater participation by providers in the Program;

29 [(9)] (10) Promote individual responsibility for maintaining good health
30 habits;

31 [(10)] (11) Encourage the Program and Maryland's Health Care
32 Regulatory System to work to cooperatively promote the development of an
33 appropriate mix of health care providers, limit cost increases for the delivery of health
34 care to Program recipients, and insure the delivery of quality health care to Program
35 recipients;

1 [(11)] (12) Encourage the development and utilization of cost-effective
2 and preventive alternatives to the delivery of health care services to appropriate
3 Program recipients in inpatient institutional settings;

4 [(12)] (13) Encourage the appropriate executive agencies to coordinate
5 the eligibility determination, policy, operations, and compliance components of the
6 Program;

7 [(13)] (14) Work with representatives of inpatient institutions, third
8 party payors, and the appropriate State agencies to contain Program costs;

9 [(14)] (15) Identify and seek to develop an optimal mix of State, federal,
10 and privately financed health care services for Program recipients, within available
11 resources through cooperative interagency efforts;

12 [(15)] (16) Develop joint legislative and executive branch strategies to
13 persuade the federal government to reconsider those policies that discourage the
14 delivery of cost-effective health care to Program recipients;

15 [(16)] (17) Evaluate departmental recommendations as to those persons
16 whose financial need or health care needs are most acute;

17 [(17)] (18) Establish mechanisms for aggressively pursuing recoveries
18 against third parties permitted under current law and exploring additional methods
19 for seeking to recover other moneys expended by the Program; and

20 [(18)] (19) Take appropriate measures to assure the quality of health care
21 services provided by managed care organizations.

22 15-102.5.

23 (a) [A] SUBJECT TO SUBSECTION (B) OF THIS SECTION, A health maintenance
24 organization that requires its panel providers to participate in a managed care
25 organization shall establish a mechanism, subject to review by the Secretary, which
26 provides for equitable distribution of enrollees and which ensures that a provider will
27 not be assigned a disproportionate number of enrollees.

28 (B) IF A PROGRAM RECIPIENT DESIRES TO CONTINUE CARE WITH A PROVIDER
29 WHO WAS IDENTIFIED BY THE DEPARTMENT DURING THE ENROLLMENT PROCESS
30 AS THE RECIPIENT'S PRIMARY CARE PROVIDER AND THE MANAGED CARE
31 ORGANIZATION HAS A CONTRACT WITH THE PROVIDER, THE MANAGED CARE
32 ORGANIZATION SHALL SEEK TO ASSURE THE RECIPIENT'S CONTINUITY OF CARE BY
33 ASSIGNING THE RECIPIENT TO THE PROVIDER.

34 [(b)] (C) Nothing in this section may be interpreted as prohibiting a provider
35 from voluntarily accepting additional enrollees.

1 15-103.

2 (b) (23) (i) The Department shall adopt regulations relating to enrollment,
3 disenrollment, and enrollee appeals.

4 (ii) [An] SUBJECT TO SUBPARAGRAPH (III) OF THIS PARAGRAPH,
5 AN enrollee may disenroll from a managed care organization:

6 1. Without cause in the month following the anniversary
7 date of the enrollee's enrollment; [and]

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

9 3. IF THE ENROLLEE'S PRIMARY CARE PROVIDER
10 TERMINATES THE PROVIDER'S CONTRACT WITH A MANAGED CARE ORGANIZATION,
11 THE PROVIDER CONTRACTS WITH AT LEAST ONE OTHER MANAGED CARE
12 ORGANIZATION, AND THE ENROLLEE DESIRES TO CONTINUE TO RECEIVE CARE
13 FROM THE PROVIDER; OR

14 4. IF A MANAGED CARE ORGANIZATION TERMINATES ITS
15 CONTRACT WITH THE DEPARTMENT OR IS ACQUIRED BY ANOTHER ENTITY, THE
16 ENROLLEE'S PRIMARY CARE PROVIDER HAS A CONTRACT WITH AT LEAST ONE OTHER
17 MANAGED CARE ORGANIZATION, AND THE ENROLLEE DESIRES TO CONTINUE TO
18 RECEIVE CARE FROM THE PROVIDER.

19 (III) AN ENROLLEE WHO DISENROLLS FROM A MANAGED CARE
20 ORGANIZATION AS AUTHORIZED UNDER ITEMS 3 AND 4 OF SUBPARAGRAPH (II) OF
21 THIS PARAGRAPH SHALL SIMULTANEOUSLY ENROLL IN ANOTHER MANAGED CARE
22 ORGANIZATION WITH WHOM THE ENROLLEE'S PRIMARY CARE PROVIDER HAS A
23 CONTRACT.

24 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
25 October 1, 1999.