
By: **Senator Exum**
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Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
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CHAPTER _____

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 assistance, maintaining continuity of care with that provider, and promoting
7 continuity of care for a newborn; requiring a managed care organization, under
8 certain circumstances, to assign a recipient of medical assistance to ~~the~~
9 recipient's primary care provider as identified by the Department during the
10 enrollment process; allowing an enrollee in the Maryland Medical Assistance
11 Program to disenroll under certain circumstances a particular primary care
12 provider and to honor a request to change primary care providers; allowing a
13 recipient to disenroll from a managed care organization under certain
14 circumstances; requiring the Department to provide a certain notification;
15 requiring a managed care organization to establish a certain system to identify
16 the name of a certain primary care provider; and generally relating to the
17 Maryland Medical Assistance Program and continuity of care for program
18 recipients.

19 BY repealing and reenacting, with amendments,
20 Article - Health - General
21 Section ~~15-102.1, 15-102.5, and 15-103(b)(23)~~ 15-102.5 and 15-103(b)(9)(xiv)
22 and (xv) and (23)
23 Annotated Code of Maryland
24 (1994 Replacement Volume and 1998 Supplement)

25 BY adding to

1 Article - Health - General
 2 Section 15-103(b)(9)(xvi) and (f)
 3 Annotated Code of Maryland
 4 (1994 Replacement Volume and 1998 Supplement)

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

7 **Article - Health - General**

8 ~~15-102.1.~~

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

12 (b) ~~The Department shall, to the extent permitted, subject to the limitations of~~
 13 ~~the State budget:~~

14 (1) ~~Provide a comprehensive system of quality health care services with~~
 15 ~~an emphasis on prevention, education, individualized care, and appropriate case~~
 16 ~~management;~~

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

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

21 (4) ~~Seek to coordinate the Program activities with other State programs~~
 22 ~~and initiatives that are necessary to address the health care needs of the population~~
 23 ~~served by the Program;~~

24 (5) ~~Promote Program policies that facilitate access to and continuity of~~
 25 ~~care by encouraging:~~

26 (i) ~~Provider availability throughout the State;~~

27 (ii) ~~Consumer education;~~

28 (iii) ~~The development of ongoing relationships between Program~~
 29 ~~recipients and primary health care providers; and~~

30 (iv) ~~The regular review of the Program's regulations to determine~~
 31 ~~whether the administrative requirements of those regulations are unnecessarily~~
 32 ~~burdensome on Program providers;~~

33 (6) ~~ESTABLISH MECHANISMS FOR IDENTIFYING A PROGRAM~~
 34 ~~RECIPIENT'S PRIMARY CARE PROVIDER AT THE TIME OF ENROLLMENT AND, IF THE~~
 35 ~~PROVIDER HAS A CONTRACT WITH A MANAGED CARE ORGANIZATION AND THE~~

1 ~~RECIPIENT DESIRES TO CONTINUE CARE WITH THE PROVIDER, MECHANISMS FOR~~
2 ~~ASSIGNING THE PROGRAM RECIPIENT TO THE PROVIDER;~~

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

5 ~~[(7)]~~ (8) Require health care providers who participate in the Program to
6 provide access to Program recipients on a nondiscriminatory basis in accordance with
7 State and federal law;

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

10 ~~[(9)]~~ (10) Promote individual responsibility for maintaining good health
11 habits;

12 ~~[(10)]~~ (11) Encourage the Program and Maryland's Health Care
13 Regulatory System to work to cooperatively promote the development of an
14 appropriate mix of health care providers, limit cost increases for the delivery of health
15 care to Program recipients, and insure the delivery of quality health care to Program
16 recipients;

17 ~~[(11)]~~ (12) Encourage the development and utilization of cost-effective
18 and preventive alternatives to the delivery of health care services to appropriate
19 Program recipients in inpatient institutional settings;

20 ~~[(12)]~~ (13) Encourage the appropriate executive agencies to coordinate
21 the eligibility determination, policy, operations, and compliance components of the
22 Program;

23 ~~[(13)]~~ (14) Work with representatives of inpatient institutions, third
24 party payors, and the appropriate State agencies to contain Program costs;

25 ~~[(14)]~~ (15) Identify and seek to develop an optimal mix of State, federal,
26 and privately financed health care services for Program recipients, within available
27 resources through cooperative interagency efforts;

28 ~~[(15)]~~ (16) Develop joint legislative and executive branch strategies to
29 persuade the federal government to reconsider those policies that discourage the
30 delivery of cost-effective health care to Program recipients;

31 ~~[(16)]~~ (17) Evaluate departmental recommendations as to those persons
32 whose financial need or health care needs are most acute;

33 ~~[(17)]~~ (18) Establish mechanisms for aggressively pursuing recoveries
34 against third parties permitted under current law and exploring additional methods
35 for seeking to recover other moneys expended by the Program; and

36 ~~[(18)]~~ (19) Take appropriate measures to assure the quality of health care
37 services provided by managed care organizations.

1 15-102.5.

2 (a) [A] ~~SUBJECT TO SUBSECTION (B) OF THIS SECTION § 15-103(F) OF THIS~~
 3 SUBTITLE, A health maintenance organization that requires its panel providers to
 4 participate in a managed care organization shall establish a mechanism, subject to
 5 review by the Secretary, which provides for equitable distribution of enrollees and
 6 which ensures that a provider will not be assigned a disproportionate number of
 7 enrollees.

8 ~~(B) IF A PROGRAM RECIPIENT DESIRES TO CONTINUE CARE WITH A PROVIDER~~
 9 ~~WHO WAS IDENTIFIED BY THE DEPARTMENT DURING THE ENROLLMENT PROCESS~~
 10 ~~AS THE RECIPIENT'S PRIMARY CARE PROVIDER AND THE MANAGED CARE~~
 11 ~~ORGANIZATION HAS A CONTRACT WITH THE PROVIDER, THE MANAGED CARE~~
 12 ~~ORGANIZATION SHALL SEEK TO ASSURE THE RECIPIENT'S CONTINUITY OF CARE BY~~
 13 ~~ASSIGNING THE RECIPIENT TO THE PROVIDER.~~

14 [(b)] ~~(C)~~ (B) Nothing in this section may be interpreted as prohibiting a
 15 provider from voluntarily accepting additional enrollees.

16 15-103.

17 (b) (9) Each managed care organization shall:

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

20 1. The basic health risk assessment conducted on
 21 enrollment;

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

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

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

31 (xv) Upon provision of information specified by the Department
 32 under paragraph (19) of this subsection, pay school-based clinics for services provided
 33 to the managed care organization's enrollees; AND

34 (XVI) ESTABLISH A USER-FRIENDLY SYSTEM THAT OPERATES AT
 35 LEAST 8 HOURS PER DAY, 5 DAYS PER WEEK, TO QUICKLY AND EFFICIENTLY
 36 IDENTIFY THE NAME OF THE PRIMARY CARE PROVIDER ASSIGNED TO AN ENROLLEE.

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

3 (ii) [~~An~~] ~~SUBJECT TO SUBPARAGRAPH (III) OF THIS PARAGRAPH~~
4 SUBSECTION (F)(4) AND (5) OF THIS SECTION, AN enrollee may disenroll from a
5 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 (F) (1) THE DEPARTMENT SHALL ESTABLISH MECHANISMS FOR:

25 (I) IDENTIFYING A PROGRAM RECIPIENT'S PRIMARY CARE
26 PROVIDER AT THE TIME OF ENROLLMENT INTO A MANAGED CARE PROGRAM;

27 (II) MAINTAINING CONTINUITY OF CARE WITH THE PRIMARY CARE
28 PROVIDER IF:

29 1. THE PROVIDER HAS A CONTRACT WITH A MANAGED CARE
30 ORGANIZATION OR A CONTRACTED MEDICAL GROUP OF A MANAGED CARE
31 ORGANIZATION TO PROVIDE PRIMARY CARE SERVICES; AND

32 2. THE RECIPIENT DESIRES TO CONTINUE CARE WITH THE
33 PROVIDER; AND

34 (III) PROMOTING CONTINUITY OF CARE FOR A NEWBORN,
35 INCLUDING:

36 1. FACILITATING IDENTIFICATION OF THE PRIMARY CARE
37 PROVIDER FOR A NEWBORN PRIOR TO BIRTH;

1 2. ASSURING ENROLLMENT OF A NEWBORN WITH A
2 PRIMARY CARE PROVIDER WHO PARTICIPATES IN THE MANAGED CARE
3 ORGANIZATION OF THE MOTHER; AND

4 3. ASSURING REIMBURSEMENT TO THE PRIMARY CARE
5 PROVIDER WHO DELIVERS CARE DURING THE NEWBORN PERIOD.

6 (2) IF A PROGRAM RECIPIENT ENROLLS IN A MANAGED CARE
7 ORGANIZATION AND REQUESTS ASSIGNMENT TO A PARTICULAR PRIMARY CARE
8 PROVIDER WHO HAS A CONTRACT WITH THE MANAGED CARE ORGANIZATION OR A
9 CONTRACTED GROUP OF THE MANAGED CARE ORGANIZATION, THE MANAGED CARE
10 ORGANIZATION SHALL ASSIGN THE RECIPIENT TO THE PRIMARY CARE PROVIDER.

11 (3) A PROGRAM RECIPIENT MAY REQUEST A CHANGE OF PRIMARY CARE
12 PROVIDERS AT ANY TIME AND, IF THE PRIMARY CARE PROVIDER HAS A CONTRACT
13 WITH THE MANAGED CARE ORGANIZATION OR A CONTRACTED GROUP OF THE
14 MANAGED CARE ORGANIZATION, THE MANAGED CARE ORGANIZATION SHALL HONOR
15 THE REQUEST.

16 (4) WHEN THERE IS A CHANGE OF MANAGED CARE ORGANIZATION
17 OWNERSHIP OR WHEN A MANAGED CARE ORGANIZATION TERMINATES ITS
18 CONTRACT WITH THE DEPARTMENT, A PROGRAM RECIPIENT MAY DISENROLL FROM
19 A MANAGED CARE ORGANIZATION IN ACCORDANCE WITH WRITTEN GUIDANCE
20 PROVIDED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION.

21 (5) A PROGRAM RECIPIENT MAY DISENROLL FROM A MANAGED CARE
22 ORGANIZATION TO MAINTAIN CONTINUITY OF CARE WITH A PRIMARY CARE
23 PROVIDER IF:

24 (1) THE CONTRACT BETWEEN THE PRIMARY CARE PROVIDER AND
25 THE MANAGED CARE ORGANIZATION OR CONTRACTED GROUP OF THE MANAGED
26 CARE ORGANIZATION TERMINATES BECAUSE:

27 1. THE MANAGED CARE ORGANIZATION OR CONTRACTED
28 GROUP OF THE MANAGED CARE ORGANIZATION TERMINATES THE PROVIDER'S
29 CONTRACT FOR A REASON OTHER THAN QUALITY OF CARE; OR

30 2. THE MANAGED CARE ORGANIZATION OR CONTRACTED
31 GROUP OF THE MANAGED CARE ORGANIZATION PROPOSES TO REDUCE THE PRIMARY
32 CARE PROVIDER'S COMPENSATION RATE AND THE PROVIDER AND THE MANAGED
33 CARE ORGANIZATION OR CONTRACTED GROUP OF THE MANAGED CARE
34 ORGANIZATION ARE UNABLE TO NEGOTIATE A MUTUALLY ACCEPTABLE RATE; AND

35 (II) 1. THE PROGRAM RECIPIENT DESIRES TO CONTINUE TO
36 RECEIVE CARE FROM THE PRIMARY CARE PROVIDER;

37 2. THE PROVIDER CONTRACTS WITH AT LEAST ONE OTHER
38 MANAGED CARE ORGANIZATION OR CONTRACTED GROUP OF A MANAGED CARE
39 ORGANIZATION; AND

