SENATE BILL 636

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By: **Senators Kelley, Conway, Currie, Hafer, Hooper, Hughes, Kasemeyer, Madden, Mitchell, Pinsky, and Sfikas**
Introduced and read first time: February 2, 2001
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Medicaid Managed Care Organizations - Continuity of Care

FOR the purpose of providing that a HealthChoice Program recipient has the right to choose the managed care organization with which the recipient is enrolled and the primary care provider to whom the recipient is assigned within the managed care organization; authorizing the Program, under certain conditions, to assign a recipient to a managed care organization that contracts with the recipient's most recent primary care provider and requiring the Department of Health and Mental Hygiene to identify the primary care provider to the managed care organization at the time of assignment; requiring the Department to establish mechanisms for maintaining a database that identifies each Program recipient's current primary care provider and managed care organization; expanding the conditions under which a managed care organization must assign a recipient to a managed care provider; and generally relating to the HealthChoice Program and the selection or assignment of managed care organizations and primary care providers for Program recipients.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-103(b)(23) and (f)
Annotated Code of Maryland
(2000 Replacement Volume)

Preamble

WHEREAS, The Medical Assistance Program was designed to "promote Program policies that facilitate access to and continuity of care"; and

WHEREAS, One of the original goals of the HealthChoice Program was to "provide enrollees with a medical home"; and

WHEREAS, The vast majority of enrollees in the HealthChoice Program are children, and the American Academy of Pediatrics defines the "medical home" as care delivered by a well-trained physician known to the child and family, over an extended

period of time, to enhance continuity and develop a relationship of mutual responsibility and trust; and

WHEREAS, A medical home is particularly essential to children with special needs who typically require care from a variety of medical and nonmedical providers; and

WHEREAS, Three years into the HealthChoice Program, the Department is collecting encounter data and enrollment preferences, but these data systems do not "speak" to each other and the Department does not currently know the primary care provider of each enrollee; and

WHEREAS, During the first transition of enrollees to new managed care organizations following the withdrawal of managed care organizations from the State, 70 percent of enrollees living in Baltimore City and 50 percent of enrollees statewide did not choose their new managed care organization, so that enrollees had to be randomly assigned to new managed care organizations which may not have had contractual relationships with their primary care providers; and

WHEREAS, The encounter data for all enrollees is currently being collected in one database at the Center for Health Program Development and Management; now, therefore,

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

Article - Health - General

15-103.

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

(II) PROGRAM RECIPIENTS SHALL HAVE THE RIGHT TO CHOOSE:

1. THE MANAGED CARE ORGANIZATION WITH WHICH THEY ARE ENROLLED; AND

2. THE PRIMARY CARE PROVIDER TO WHOM THEY ARE ASSIGNED WITHIN THE MANAGED CARE ORGANIZATION.

(III) IF A PROGRAM RECIPIENT DOES NOT SELECT A MANAGED CARE ORGANIZATION, THE DEPARTMENT SHALL ASSIGN THE RECIPIENT TO A MANAGED CARE ORGANIZATION THAT CONTRACTS WITH THE RECIPIENT'S PRIMARY CARE PROVIDER IDENTIFIED UNDER SUBSECTION (F)(1)(I) OF THIS SECTION.

(IV) AT THE TIME OF REENROLLMENT OR WHENEVER A CHANGE IN THE PROGRAM REQUIRES A RECIPIENT TO SELECT A NEW MANAGED CARE ORGANIZATION, IF A RECIPIENT DOES NOT SELECT A MANAGED CARE ORGANIZATION, THE DEPARTMENT SHALL:

1. ASSIGN THE RECIPIENT TO A MANAGED CARE ORGANIZATION THAT CONTRACTS WITH THE RECIPIENT'S MOST RECENT PRIMARY CARE PROVIDER, AS IDENTIFIED IN THE DATABASE MAINTAINED UNDER SUBSECTION (F)(1) OF THIS SECTION; AND

2. IDENTIFY THE PRIMARY CARE PROVIDER TO THE MANAGED CARE ORGANIZATION AT THE TIME OF ASSIGNMENT.

[(ii)] (V) Subject to subsection (f)(4) and (5) of this section, 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.

(f) (1) The Department shall establish mechanisms for:

(i) Identifying a Program recipient's primary care provider at the time of enrollment into a managed care program; [and]

(II) MAINTAINING A DATABASE THAT IDENTIFIES EACH PROGRAM RECIPIENT'S CURRENT PRIMARY CARE PROVIDER;

(III) IDENTIFYING A PROGRAM RECIPIENT'S MANAGED CARE ORGANIZATION AND PRIMARY CARE PROVIDER THROUGH THE ELIGIBILITY VERIFICATION SYSTEM MAINTAINED BY THE DEPARTMENT; AND

[(ii)] (IV) Maintaining continuity of care with the primary care provider if:

1. The provider has a contract with a managed care organization or a contracted medical group of a managed care organization to provide primary care services; and

2. The recipient desires to continue care with the provider.

(2) A MANAGED CARE ORGANIZATION SHALL ASSIGN A RECIPIENT TO A PRIMARY CARE PROVIDER IF:

(I) [If a] THE Program recipient enrolls in [a] THE managed care organization and requests assignment to a particular primary care provider who has a contract with the managed care organization or a contracted group of the managed care organization[, the managed care organization shall assign the recipient to the primary care provider]; OR

(II) THE PROGRAM RECIPIENT IS ASSIGNED TO A MANAGED CARE ORGANIZATION, THE DEPARTMENT IDENTIFIES THE RECIPIENT'S PRIMARY CARE PROVIDER, AND THE PROVIDER HAS A CONTRACT WITH THE MANAGED CARE ORGANIZATION OR A CONTRACTED GROUP OF THE MANAGED CARE ORGANIZATION.

(3) A Program recipient may request a change of primary care providers within the same managed care organization at any time and, if the primary care provider has a contract with the managed care organization or a contracted group of the managed care organization, the managed care organization shall honor the request.

(4) In accordance with the federal Health Care Financing Administration's guidelines, a Program recipient may elect to disenroll from a managed care organization if the managed care organization terminates its contract with the Department.

(5) A Program recipient may disenroll from a managed care organization to maintain continuity of care with a primary care provider if:

(i) The contract between the primary care provider and the managed care organization or contracted group of the managed care organization terminates because:

1. The managed care organization or contracted group of the managed care organization terminates the provider's contract for a reason other than quality of care or the provider's failure to comply with contractual requirements related to quality assurance activities;

2. A. The managed care organization or contracted group of the managed care organization reduces the primary care provider's capitated or applicable fee for services rates;

B. The reduction in rates is greater than the actual change in rates or capitation paid to the managed care organization by the Department; and

C. The provider and the managed care organization or contracted group of the managed care organization are unable to negotiate a mutually acceptable rate; or

3. The provider contract between the provider and the managed care organization is terminated because the managed care organization is acquired by another entity; and

(ii) 1. The Program recipient desires to continue to receive care from the primary care provider;

2. The provider contracts with at least one other managed care organization or contracted group of a managed care organization; and

3. The enrollee notifies the Department or the Department's designee of the enrollee's intention within 90 days after the contract termination.

(6) The Department shall provide timely notification to the affected managed care organization of an enrollee's intention to disenroll under the provisions of paragraph (5) of this subsection.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2001.