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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				
Committee Report: Favorable with amendments Senate action: Adopted Read second time: March 23, 2001				
	CHAPTER			

#### 1 AN ACT concerning

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#### Medicaid Managed Care Organizations - Continuity of Care

- 3 FOR the purpose of providing that a HealthChoice Program recipient has the right to
- 4 choose the managed care organization with which the recipient is enrolled and
- 5 the primary care provider to whom the recipient is assigned within the managed
- 6 care organization; authorizing the Program, under certain conditions, to assign
- 7 a recipient to a managed care organization that contracts with the recipient's
- 8 most recent primary care provider and requiring the Department of Health and
- 9 Mental Hygiene to identify the primary care provider to the managed care
- organization at the time of assignment; requiring the Department to establish
- 11 mechanisms for maintaining a database that identifies each Program recipient's
- 12 current primary care provider and managed care organization; expanding the
- 13 conditions under which a managed care organization must assign a recipient to
- 14 a managed care provider requiring the Department of Health and Mental
- 15 Hygiene to reassign a disenrolled recipient to a certain managed care
- 16 <u>organization under certain circumstances; requiring a managed care</u>
- organization to assign a certain primary care provider to a disensolled recipient
- 18 under certain circumstances; requiring a managed care organization that is
- withdrawing from the HealthChoice Program to provide a certain written notice
- 20 to a recipient within a certain time; requiring a managed care organization to
- 21 provide the Department with a certain list of recipients and their primary care
- 22 <u>providers by a certain time</u>; and generally relating to the HealthChoice Program
- and the selection or assignment of managed care organizations and primary
- 24 care providers for Program recipients.
- 25 BY repealing and reenacting, with amendments,
- 26 Article Health General

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Section 15-103(b)(23) and (f)

2	Annotated Code of Maryland (2000 Replacement Volume)			
4	Preamble			
5 6	WHEREAS, The Medical Assistance Program was designed to "promote Program policies that facilitate access to and continuity of care"; and			
7 8	WHEREAS, One of the original goals of the HealthChoice Program was to "provide enrollees with a medical home"; and			
11 12	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			
19	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			
23 24 25	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,			
30 31	SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:			
32	Article - Health - General			
33	15-103.			
34 35	(b) (23) (i) The Department shall adopt regulations relating to enrollment, disenrollment, and enrollee appeals.			
36	(II) PROGRAM RECIPIENTS SHALL HAVE THE RIGHT TO CHOOSE:			

# SENATE BILL 636

1 2	1. THE MANAGED CARE ORGANIZATION WITH WHICH THEY ARE ENROLLED; AND
3	2. THE PRIMARY CARE PROVIDER TO WHOM THEY ARE ASSIGNED WITHIN THE MANAGED CARE ORGANIZATION.
7	(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.
11 12	(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 IF A RECIPIENT IS DISENROLLED AND REENROLLS WITHIN 120 DAYS OF THE RECIPIENT'S DISENROLLMENT, THE DEPARTMENT SHALL:
16 17	1. ASSIGN THE RECIPIENT TO A <u>THE</u> MANAGED CARE ORGANIZATION <del>THAT CONTRACTS WITH THE RECIPIENT'S MOST RECENT PRIMARY CARE PROVIDER, AS IDENTIFIED IN THE DATABASE MAINTAINED UNDER SUBSECTION (F)(1) OF THIS SECTION IN WHICH THE RECIPIENT PREVIOUSLY WAS ENROLLED; AND</del>
21	2. IDENTIFY THE PRIMARY CARE PROVIDER TO THE MANAGED CARE ORGANIZATION AT THE TIME OF ASSIGNMENT REQUIRE THE MANAGED CARE ORGANIZATION TO ASSIGN THE RECIPIENT TO THE PRIMARY CARE PROVIDER OF RECORD AT THE TIME OF THE RECIPIENT'S DISENROLLMENT.
25	(IV) WHENEVER A RECIPIENT HAS TO SELECT A NEW MANAGED CARE ORGANIZATION BECAUSE THE RECIPIENT'S MANAGED CARE ORGANIZATION HAS WITHDRAWN FROM THE HEALTHCHOICE PROGRAM, THE WITHDRAWING MANAGED CARE ORGANIZATION:
	1. SHALL PROVIDE WRITTEN NOTICE OF REASSIGNMENT TO THE RECIPIENT 30 DAYS BEFORE WITHDRAWING FROM THE HEALTHCHOICE PROGRAM;
	2. SHALL INCLUDE IN THE NOTICE OF REASSIGNMENT THE NAME AND PROVIDER NUMBER OF THE NEW PRIMARY CARE PROVIDER ASSIGNED TO THE RECIPIENT AND THE TELEPHONE NUMBER OF THE ENROLLMENT BROKER; AND
35	3. WITHIN 30 DAYS AFTER TERMINATING ITS CONTRACT WITH THE DEPARTMENT, SHALL PROVIDE THE DEPARTMENT WITH A LIST OF RECIPIENTS WHO HAVE BEEN REASSIGNED TO ANOTHER PRIMARY CARE PROVIDER AND THE NAMES OF THE PRIMARY CARE PROVIDERS ASSIGNED TO THE RECIPIENTS.
37 38	[(ii)] (V) Subject to subsection (f)(4) and (5) of this section, an enrollee may disenroll from a managed care organization:

# SENATE BILL 636

1 2	date of the en	rollee's e	enrollmer	1. nt; and	Without cause in the month following the anniversary
3				2.	For cause, at any time as determined by the Secretary.
4	<del>(f)</del>	(1)	The Dep	oartment (	shall establish mechanisms for:
5 6	time of enroll	ment int	<del>(i)</del> o a mana		ing a Program recipient's primary care provider at the program; [and]
7 8	RECIPIENT'	S CURR	<del>(II)</del> ENT PR		AINING A DATABASE THAT IDENTIFIES EACH PROGRAM CARE PROVIDER;
				MARY C	FYING A PROGRAM RECIPIENT'S MANAGED CARE ARE PROVIDER THROUGH THE ELIGIBILITY NED BY THE DEPARTMENT; AND
12 13	<del>provider if:</del>		<del>[(ii)]</del>	<del>(IV)</del>	Maintaining continuity of care with the primary care
				<del>1.</del> <del>redical gr</del>	The provider has a contract with a managed care oup of a managed care organization to provide
17				<del>2.</del>	The recipient desires to continue care with the provider.
18 19	PRIMARY (	<del>(2)</del> CARE PI			CARE ORGANIZATION SHALL ASSIGN A RECIPIENT TO A
22 23	organization a contract wi	th the mation[, th	anaged ci e manage	<del>gnment to</del> are organ	IE Program recipient enrolls in [a] THE managed care of a particular primary care provider who has ization or a contracted group of the managed reganization shall assign the recipient to the
27 28	PROVIDER, ORGANIZA	<del>, AND T</del> <del>TION O</del>	HE PRO R A CO	PARTME VIDER I NTRACT	OGRAM RECIPIENT IS ASSIGNED TO A MANAGED CARE NT IDENTIFIES THE RECIPIENT'S PRIMARY CARE IAS A CONTRACT WITH THE MANAGED CARE 'ED GROUP OF THE MANAGED CARE ORGANIZATION.
31 32	within the sar provider has	a contra	aged care ct with th	<del>organiza</del> e manago	ent may request a change of primary care providers ution at any time and, if the primary care ed care organization or a contracted group of maged care organization shall honor the
36	Administration	<del>e organi</del> z	<del>lelines, a</del> <del>zation if t</del>	Program	th the federal Health Care Financing recipient may elect to disenroll from a ged care organization terminates its contract

### **SENATE BILL 636**

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:    Interminates because:   Interminates the provider's contract for a reason other than quality of care or the provider's failure to comply with contract for a reason other than quality of care or the provider's failure to comply with contract for a reason other than quality of care or the provider's failure to comply with contractual requirements related to quality assurance activities:    10	1	(5) A Program recipient may disenroll from a managed care organization
4 managed care organization or contracted group of the managed care organization terminates because:  6	2	
4 managed care organization or contracted group of the managed care organization terminates because:  6		
terminates because:  6		
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;  10	4	managed care organization or contracted group of the managed care organization
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;  10 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;  13 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  15 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  18 3. The provider contract between the provider and the managed care organization is acquired by another entity; and  21 (ii) 1. The Program recipient desires to continue to receive care from the primary care provider;  22 2. The provider contracts with at least one other managed care organization or contracted group of a managed care organization; and  25 3. The enrollee notifies the Department or the Department's designee of the enrollee's intention within 90 days after the contract termination.  26 (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.  27 (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.	5	terminates because:
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31 October 1, 2001.		October 1, 2001.