
By: **Delegate Morhaim**

Introduced and read first time: January 29, 2003

Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Maryland Medical Assistance Authority**

3 FOR the purpose of establishing the Maryland Medical Assistance Authority;
4 transferring oversight of certain medical assistance programs from the
5 Department of Health and Mental Hygiene to the Maryland Medical Assistance
6 Authority; defining certain terms; declaring the intent of the General Assembly;
7 providing for the purpose of the Authority; providing that the Authority is an
8 instrumentality of the State and a public corporation; providing for the
9 membership and duties of the Authority; providing for the appointment and
10 duties of the Executive Director of the Authority; providing that the Authority
11 shall administer the Maryland Medical Assistance Program, the Maryland
12 Pharmacy Discount Program, the Maryland AIDS Insurance Assistance
13 Program, and the Maryland Children's Health Program; requiring the
14 Department of Health and Mental Hygiene to apply for a certain waiver;
15 requiring the Authority to make a certain report to certain committees of the
16 General Assembly under certain circumstances; providing for the continuity of
17 certain functions, powers, duties, equipment, assets, liabilities, and employees;
18 making stylistic changes; providing for the effective date of this Act; making the
19 Act, except for a certain provision, subject to a certain contingency; and
20 generally relating to the establishment of the Maryland Medical Assistance
21 Authority and to the transfer of oversight over certain medical assistance
22 programs from the Department of Health and Mental Hygiene to the Maryland
23 Medical Assistance Authority.

24 BY repealing

25 Article - Health - General
26 Section 15-101, 15-102, 15-102.1, 15-102.2, 15-102.3, 15-102.4, 15-102.5,
27 15-102.6, 15-103, 15-103.2, 15-103.3, 15-103.4, 15-121.3, and 15-303
28 Annotated Code of Maryland
29 (2000 Replacement Volume and 2002 Supplement)

30 BY adding to

31 Article - Health - General
32 Section 15-101 through 15-105, inclusive, to be under the amended subtitle

1 "Subtitle 1. Maryland Medical Assistance Authority"; and 15-1A-01
2 through 15-1A-05 to be under the new subtitle "Subtitle 1A. Medical and
3 Pharmacy Assistance Programs"
4 Annotated Code of Maryland
5 (2000 Replacement Volume and 2002 Supplement)

6 BY repealing and reenacting, with amendments,
7 Article - Health - General
8 Section 15-103.1, 15-104 through 15-114.1, 15-115 through 15-118, 15-120
9 through 15-121.2, 15-122, 15-122.1, 15-122.2, 15-123, 15-124, 15-124.1,
10 15-124.2, 15-125 through 15-134, inclusive, 15-202 through 15-205,
11 inclusive, 15-301, 15-301.1, 15-302, 15-304, 15-305, and 15-501
12 Annotated Code of Maryland
13 (2000 Replacement Volume and 2002 Supplement)

14 BY repealing and reenacting, without amendments,
15 Article - Health - General
16 Section 15-201
17 Annotated Code of Maryland
18 (2000 Replacement Volume and 2002 Supplement)

19 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
20 MARYLAND, That Section(s) 15-101, 15-102, 15-102.1, 15-102.2, 15-102.3,
21 15-102.4, 15-102.5, 15-102.6, 15-103, 15-103.2, 15-103.3, 15-103.4, 15-121.3, and
22 15-303 of Article - Health - General of the Annotated Code of Maryland be repealed.

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

25 **Article - Health - General**

26 Subtitle 1. [Medical and Pharmacy Assistance Programs] MARYLAND MEDICAL
27 ASSISTANCE AUTHORITY.

28 15-101.

29 (A) THERE IS A BODY CORPORATE AND POLITIC KNOWN AS THE MARYLAND
30 MEDICAL ASSISTANCE AUTHORITY.

31 (B) THE PURPOSE OF THE AUTHORITY IS TO OPERATE MEDICAL ASSISTANCE
32 PROGRAMS IN THE STATE IN COMPLIANCE WITH ANY FEDERAL LAW OR
33 REGULATION.

34 (C) THE AUTHORITY IS AN INSTRUMENTALITY OF THE STATE AND A PUBLIC
35 CORPORATION BY THAT NAME, STYLE, AND TITLE.

1 (D) THE AUTHORITY IS AN INDEPENDENT UNIT IN THE EXECUTIVE BRANCH
2 OF STATE GOVERNMENT.

3 (E) THE EXERCISE BY THE AUTHORITY OF THE POWERS CONFERRED BY THIS
4 SUBTITLE IS THE PERFORMANCE OF AN ESSENTIAL PUBLIC FUNCTION.

5 15-102.

6 (A) THE AUTHORITY CONSISTS OF SEVEN MEMBERS APPOINTED BY THE
7 GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE.

8 (B) THE GOVERNOR SHALL DESIGNATE ONE OF THE MEMBERS AS CHAIRMAN.

9 (C) (1) THE TERM OF A MEMBER IS 4 YEARS.

10 (2) THE TERMS OF MEMBERS ARE STAGGERED AS REQUIRED BY THE
11 TERMS PROVIDED FOR MEMBERS OF THE BOARD ON JULY 1, 2003.

12 (3) AT THE END OF A TERM, A MEMBER CONTINUES TO SERVE UNTIL A
13 SUCCESSOR IS APPOINTED AND QUALIFIES.

14 (4) A MEMBER WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES
15 ONLY FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND
16 QUALIFIES.

17 (5) UPON THE END OF A TERM, RESIGNATION, OR REMOVAL OF A
18 MEMBER, THE GOVERNOR SHALL APPOINT A NEW MEMBER TO THE AUTHORITY WITH
19 THE ADVICE AND CONSENT OF THE SENATE.

20 (D) THE GOVERNOR MAY REMOVE A MEMBER FOR INCOMPETENCE,
21 MISCONDUCT, OR FAILURE TO PERFORM THE DUTIES OF THE POSITION.

22 15-103.

23 (A) FOUR MEMBERS OF THE AUTHORITY CONSTITUTE A QUORUM FOR THE
24 PURPOSE OF CONDUCTING BUSINESS.

25 (B) ACTIONS OF THE AUTHORITY MUST RECEIVE THE AFFIRMATIVE VOTE OF
26 AT LEAST FOUR MEMBERS.

27 (C) THE AUTHORITY SHALL DETERMINE THE TIMES AND PLACES OF ITS
28 MEETINGS.

29 15-104.

30 (A) THE AUTHORITY, WITH THE APPROVAL OF THE GOVERNOR, SHALL
31 APPOINT AN EXECUTIVE DIRECTOR, WHO IS THE CHIEF ADMINISTRATIVE OFFICER
32 OF THE AUTHORITY.

33 (B) THE EXECUTIVE DIRECTOR SERVES AT THE PLEASURE OF THE
34 AUTHORITY SUBJECT TO THE CONCURRENCE OF THE GOVERNOR.

1 (C) IN ADDITION TO ANY OTHER DUTIES SET FORTH IN THIS SUBTITLE, THE
2 EXECUTIVE DIRECTOR SHALL:

3 (1) DIRECT AND SUPERVISE THE ADMINISTRATIVE AFFAIRS AND
4 ACTIVITIES OF THE AUTHORITY, IN ACCORDANCE WITH ITS RULES, REGULATIONS,
5 AND POLICIES;

6 (2) ATTEND ALL MEETINGS OF THE AUTHORITY;

7 (3) APPROVE ALL ACCOUNTS FOR SALARIES, PER DIEM PAYMENTS, AND
8 ALLOWABLE EXPENSES OF THE AUTHORITY AND ITS EMPLOYEES AND
9 CONSULTANTS AND APPROVE ALL EXPENSES INCIDENTAL TO THE OPERATION OF
10 THE AUTHORITY;

11 (4) REPORT AND MAKE RECOMMENDATIONS TO THE AUTHORITY ON
12 PROPOSALS REGARDING MEDICAL ASSISTANCE; AND

13 (5) PERFORM ANY OTHER DUTY THAT THE AUTHORITY REQUIRES FOR
14 CARRYING OUT THE PROVISIONS OF THIS TITLE.

15 15-105.

16 IN ADDITION TO THE POWERS SET FORTH IN THIS SUBTITLE, THE AUTHORITY
17 MAY:

18 (1) ADOPT AND ALTER AN OFFICIAL SEAL;

19 (2) SUE AND BE SUED, PLEAD AND BE IMPEADED;

20 (3) ADOPT BYLAWS, RULES, AND REGULATIONS TO CARRY OUT THE
21 PROVISIONS OF THIS SUBTITLE, IN ACCORDANCE WITH THE PROVISIONS OF TITLE 10,
22 SUBTITLE 1 OF THE STATE GOVERNMENT ARTICLE;

23 (4) MAINTAIN AN OFFICE AT THE PLACE DESIGNATED BY THE
24 AUTHORITY;

25 (5) EMPLOY, EITHER AS REGULAR EMPLOYEES OR INDEPENDENT
26 CONTRACTORS, ANY PERSONNEL THAT THE AUTHORITY DETERMINES TO BE
27 NECESSARY, AND FIX THEIR COMPENSATION; AND

28 (6) APPOINT ADVISORY COMMITTEES COMPOSED OF LOCAL HEALTH
29 OFFICIALS, PROVIDER AND OTHER PUBLIC HEALTH INTEREST GROUPS, AND SUCH
30 OTHER EXPERTS AS MAY BE APPROPRIATE.

31 SUBTITLE 1A. MEDICAL AND PHARMACY ASSISTANCE PROGRAMS.

32 15-1A-01.

33 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS
34 INDICATED.

1 (B) "AUTHORITY" MEANS THE MARYLAND MEDICAL ASSISTANCE AUTHORITY,
2 ESTABLISHED UNDER THIS TITLE.

3 (C) "FACILITY" MEANS A HOSPITAL OR NURSING FACILITY INCLUDING AN
4 INTERMEDIATE CARE FACILITY, SKILLED NURSING FACILITY, COMPREHENSIVE CARE
5 FACILITY, OR EXTENDED CARE FACILITY.

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

8 (E) "PROGRAM" MEANS THE MARYLAND MEDICAL ASSISTANCE PROGRAM.

9 (F) "PROGRAM RECIPIENT" MEANS AN INDIVIDUAL WHO RECEIVES BENEFITS
10 UNDER THE PROGRAM.

11 15-1A-02.

12 THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

13 (1) IT IS A GOAL OF THIS STATE TO PROMOTE THE DEVELOPMENT OF A
14 HEALTH CARE SYSTEM THAT PROVIDES ADEQUATE AND APPROPRIATE HEALTH
15 CARE SERVICES TO INDIGENT AND MEDICALLY INDIGENT INDIVIDUALS; AND

16 (2) THE ESTABLISHMENT OF A STATE PUBLIC CORPORATION TO
17 ADMINISTER MEDICAL ASSISTANCE PROGRAMS, IN WHICH THE STATE HAS NOT
18 DEMONSTRATED THE ABILITY TO DELIVER EFFECTIVE MEDICAL CARE, WOULD
19 SERVE THE PUBLIC INTEREST.

20 15-1A-03.

21 THE AUTHORITY SHALL ADMINISTER THE MARYLAND MEDICAL ASSISTANCE
22 PROGRAM.

23 15-1A-04.

24 SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET, THE AUTHORITY SHALL:

25 (1) PROVIDE PREVENTIVE AND HOME CARE SERVICES FOR INDIGENT
26 AND MEDICALLY INDIGENT INDIVIDUALS;

27 (2) EXAMINE MECHANISMS TO MAINTAIN OR REDUCE THE NUMBER OF
28 UNINSURED IN THE STATE THROUGH:

29 (I) AUTHORIZING A PRIVATE EMPLOYER OR INDIVIDUAL TO BUY
30 IN TO THE PROGRAM AT COST; AND

31 (II) PROVIDING PREMIUM ASSISTANCE FOR PRIVATE INSURANCE
32 TO EMPLOYERS WHO EMPLOY PROGRAM RECIPIENTS OR BOTH;

33 (3) DEVELOP PROTOCOLS FOR PROVIDERS ON THE IDENTIFICATION
34 AND MANAGEMENT OF HIGH COST PROGRAM RECIPIENTS;

1 (4) ESTABLISH A MEDICAID PROGRAM, WITH AN EMPHASIS ON
2 PREVENTION AND ACCOUNTABILITY, THAT INCLUDES:

3 (I) A REQUIREMENT THAT MEDICAID ENROLLEES COMPLETE AN
4 ADVANCE DIRECTIVE, AS DEFINED IN § 5-602 OF THIS ARTICLE, IN ORDER TO
5 RECEIVE BENEFITS;

6 (II) MANDATORY PROGRAMS FOR PROVIDERS AND PROGRAM
7 RECIPIENTS, AND MECHANISMS FOR MEASURING OUTCOME DATA RELATED TO:

- 8 1. PREVENTIVE HEALTH CARE;
- 9 2. GOOD HEALTH HABITS;
- 10 3. ADDICTION;
- 11 4. TOBACCO;
- 12 5. OBESITY;
- 13 6. END-OF-LIFE CARE;
- 14 7. THE VALUE OF DEVELOPING ONGOING RELATIONSHIPS
15 WITH PRIMARY CARE AND LOWER COST PROVIDERS; AND
- 16 8. ANY OTHER PROGRAM THAT THE AUTHORITY FINDS
17 NECESSARY;

18 (III) MECHANISMS FOR MEASURING APPOINTMENT COMPLIANCE,
19 NONESSENTIAL EMERGENCY ROOM VISITS, SMOKING CESSATION, DRUG USE,
20 WEIGHT CONTROL, AND ANY OTHER MEASUREMENT MECHANISM THAT THE
21 AUTHORITY FINDS NECESSARY; AND

22 (IV) A SYSTEM OF ACCOUNTABILITY FOR ENROLLEES TO
23 ENCOURAGE COMPLIANCE AND DISCOURAGE NONCOMPLIANCE;

24 (5) DEVELOP A PRENATAL CARE PROGRAM FOR PROGRAM RECIPIENTS
25 AND ENCOURAGE ITS UTILIZATION;

26 (6) ALLOCATE STATE RESOURCES FOR THE PROGRAM TO PROVIDE A
27 BALANCED SYSTEM OF HEALTH CARE SERVICES TO THE POPULATION SERVED BY
28 THE PROGRAM;

29 (7) SEEK TO COORDINATE PROGRAM ACTIVITIES WITH OTHER STATE
30 PROGRAMS AND INITIATIVES THAT ARE NECESSARY TO ADDRESS THE HEALTH CARE
31 NEEDS OF THE POPULATION SERVED BY THE PROGRAM;

32 (8) PROMOTE PROGRAM POLICIES THAT FACILITATE ACCESS TO AND
33 CONTINUITY OF CARE BY ENCOURAGING:

34 (I) PROVIDER AVAILABILITY THROUGHOUT THE STATE;

1 (II) CONSUMER EDUCATION;

2 (III) THE DEVELOPMENT OF ONGOING RELATIONSHIPS BETWEEN
3 PROGRAM RECIPIENTS AND PRIMARY HEALTH CARE PROVIDERS; AND

4 (IV) THE REGULAR REVIEW OF THE PROGRAM'S REGULATIONS TO
5 DETERMINE WHETHER THE ADMINISTRATIVE REQUIREMENTS OF THOSE
6 REGULATIONS ARE UNNECESSARILY BURDENSOME ON PROGRAM PROVIDERS;

7 (9) STRONGLY URGE HEALTH CARE PROVIDERS TO PARTICIPATE IN THE
8 PROGRAM AND THEREBY ADDRESS THE NEEDS OF PROGRAM RECIPIENTS;

9 (10) REQUIRE HEALTH CARE PROVIDERS WHO PARTICIPATE IN THE
10 PROGRAM TO PROVIDE ACCESS TO PROGRAM RECIPIENTS ON A
11 NONDISCRIMINATORY BASIS IN ACCORDANCE WITH STATE AND FEDERAL LAW;

12 (11) SEEK TO PROVIDE APPROPRIATE LEVELS OF REIMBURSEMENT FOR
13 PROVIDERS TO ENCOURAGE GREATER PARTICIPATION BY PROVIDERS IN THE
14 PROGRAM;

15 (12) ENCOURAGE THE PROGRAM AND MARYLAND'S HEALTH CARE
16 REGULATORY SYSTEM TO WORK TO COOPERATIVELY PROMOTE THE DEVELOPMENT
17 OF AN APPROPRIATE MIX OF HEALTH CARE PROVIDERS, LIMIT COST INCREASES FOR
18 THE DELIVERY OF HEALTH CARE TO PROGRAM RECIPIENTS, AND ENSURE THE
19 DELIVERY OF QUALITY HEALTH CARE TO PROGRAM RECIPIENTS;

20 (13) ENCOURAGE THE DEVELOPMENT AND UTILIZATION OF COST
21 EFFECTIVE AND PREVENTIVE ALTERNATIVES TO THE DELIVERY OF HEALTH CARE
22 SERVICES TO APPROPRIATE PROGRAM RECIPIENTS IN INPATIENT INSTITUTIONAL
23 SETTINGS;

24 (14) ENCOURAGE THE APPROPRIATE EXECUTIVE AGENCIES TO
25 COORDINATE THE ELIGIBILITY DETERMINATION, POLICY, OPERATIONS, AND
26 COMPLIANCE COMPONENTS OF THE PROGRAM;

27 (15) WORK WITH REPRESENTATIVES OF INPATIENT INSTITUTIONS, THIRD
28 PARTY PAYORS, AND THE APPROPRIATE STATE AGENCIES TO CONTAIN PROGRAM
29 COSTS;

30 (16) IDENTIFY AND SEEK TO DEVELOP AN OPTIMAL MIX OF STATE,
31 FEDERAL, AND PRIVATELY FINANCED HEALTH CARE SERVICES FOR PROGRAM
32 RECIPIENTS, WITHIN AVAILABLE RESOURCES THROUGH COOPERATIVE
33 INTERAGENCY EFFORTS;

34 (17) DEVELOP JOINT LEGISLATIVE AND EXECUTIVE BRANCH
35 STRATEGIES TO PERSUADE THE FEDERAL GOVERNMENT TO RECONSIDER THOSE
36 POLICIES THAT DISCOURAGE THE DELIVERY OF COST-EFFECTIVE HEALTH CARE
37 SERVICES TO PROGRAM RECIPIENTS;

1 (18) EVALUATE AUTHORITY RECOMMENDATIONS AS TO THOSE PERSONS
2 WHOSE FINANCIAL NEED OR HEALTH CARE NEEDS ARE MOST ACUTE; AND

3 (19) ESTABLISH MECHANISMS FOR AGGRESSIVELY PURSUING
4 RECOVERIES AGAINST THIRD PARTIES PERMITTED UNDER CURRENT LAW AND
5 EXPLORING ADDITIONAL METHODS FOR SEEKING TO RECOVER OTHER MONEYS
6 EXPENDED BY THE PROGRAM.

7 15-1A-05.

8 (A) (1) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET, THE
9 PROGRAM SHALL PROVIDE COMPREHENSIVE MEDICAL AND OTHER HEALTH CARE
10 SERVICES FOR:

11 (I) INDIGENT INDIVIDUALS AND MEDICALLY INDIGENT
12 INDIVIDUALS;

13 (II) ELIGIBLE PREGNANT WOMEN WHOSE FAMILY INCOME IS AT OR
14 BELOW 250% OF THE POVERTY LEVEL, AS PERMITTED BY FEDERAL LAW;

15 (III) ELIGIBLE CHILDREN CURRENTLY UNDER THE AGE OF 1 WHOSE
16 FAMILY INCOME FALLS BELOW 185% OF THE POVERTY LEVEL, AS PERMITTED BY
17 FEDERAL LAW;

18 (IV) CHILDREN FROM THE AGE OF 1 YEAR UP THROUGH AND
19 INCLUDING THE AGE OF 5 YEARS WHOSE FAMILY INCOME FALLS BELOW 133% OF
20 THE POVERTY LEVEL, AS PERMITTED BY FEDERAL LAW;

21 (V) CHILDREN BORN AFTER SEPTEMBER 30, 1983 WHO ARE AT
22 LEAST 6 YEARS OF AGE BUT ARE UNDER 19 YEARS OF AGE WHOSE FAMILY INCOME
23 FALLS BELOW 100% OF THE POVERTY LEVEL, AS PERMITTED BY FEDERAL LAW;

24 (VI) LEGAL IMMIGRANTS WHO MEET PROGRAM ELIGIBILITY
25 STANDARDS AND WHO ARRIVED IN THE UNITED STATES BEFORE AUGUST 22, 1996,
26 THE EFFECTIVE DATE OF THE FEDERAL PERSONAL RESPONSIBILITY AND WORK
27 OPPORTUNITY RECONCILIATION ACT, AS PERMITTED BY FEDERAL LAW; AND

28 (VII) SUBJECT TO ANY OTHER REQUIREMENTS IMPOSED BY THE
29 STATE, LEGAL IMMIGRANT CHILDREN UNDER THE AGE OF 18 YEARS AND PREGNANT
30 WOMEN WHO MEET PROGRAM ELIGIBILITY STANDARDS AND WHO ARRIVED IN THE
31 UNITED STATES ON OR AFTER AUGUST 22, 1996, THE EFFECTIVE DATE OF THE
32 FEDERAL PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION
33 ACT.

34 (2) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET, THE
35 PROGRAM:

36 (I) MAY INCLUDE BEDSIDE NURSING CARE FOR ELIGIBLE
37 PROGRAM RECIPIENTS; AND

1 (II) SHALL PROVIDE FAMILY PLANNING SERVICES TO WOMEN
2 CURRENTLY ELIGIBLE FOR COMPREHENSIVE MEDICAL CARE AND OTHER HEALTH
3 CARE UNDER PARAGRAPH (1)(II) OF THIS SUBSECTION.

4 (3) SUBJECT TO RESTRICTIONS IN FEDERAL LAW OR WAIVERS, THE
5 AUTHORITY MAY IMPOSE COST-SHARING ON PROGRAM RECIPIENTS.

6 (B) (1) (I) IN THIS SUBSECTION THE FOLLOWING WORDS HAVE THE
7 MEANINGS INDICATED.

8 (II) "CERTIFIED NURSE PRACTITIONER" MEANS A REGISTERED
9 NURSE WHO IS LICENSED IN THIS STATE, HAS COMPLETED A NURSE PRACTITIONER
10 PROGRAM APPROVED BY THE STATE BOARD OF NURSING, AND HAS PASSED AN
11 EXAMINATION APPROVED BY THAT BOARD.

12 (III) "NURSE ANESTHETIST" MEANS A REGISTERED NURSE WHO IS:

13 1. CERTIFIED UNDER THE HEALTH OCCUPATIONS ARTICLE
14 TO PRACTICE NURSE ANESTHESIA; AND

15 2. CERTIFIED BY THE COUNCIL ON CERTIFICATION OR THE
16 COUNCIL ON RECERTIFICATION OF NURSE ANESTHETISTS.

17 (IV) "NURSE MIDWIFE" MEANS A REGISTERED NURSE WHO IS
18 LICENSED IN THIS STATE AND HAS BEEN CERTIFIED BY THE AMERICAN COLLEGE OF
19 NURSE-MIDWIVES AS A NURSE MIDWIFE.

20 (V) "OPTOMETRIST" HAS THE MEANING STATED IN § 11-101 OF THE
21 HEALTH OCCUPATIONS ARTICLE.

22 (2) THE AUTHORITY MAY CONTRACT FOR THE PROVISION OF CARE
23 UNDER THE PROGRAM TO ELIGIBLE PROGRAM RECIPIENTS.

24 (3) THE AUTHORITY MAY CONTRACT WITH INSURANCE COMPANIES OR
25 NONPROFIT HEALTH SERVICE PLANS OR WITH INDIVIDUALS, ASSOCIATIONS,
26 PARTNERSHIPS, INCORPORATED OR UNINCORPORATED GROUPS OF PHYSICIANS,
27 CHIROPRACTORS, DENTISTS, PODIATRISTS, OPTOMETRISTS, PHARMACISTS,
28 HOSPITALS, NURSING HOMES, NURSES, INCLUDING NURSE ANESTHETISTS, NURSE
29 MIDWIVES AND CERTIFIED NURSE PRACTITIONERS, OPTICIANS, AND OTHER HEALTH
30 PRACTITIONERS WHO ARE LICENSED OR CERTIFIED IN THIS STATE AND PERFORM
31 SERVICES ON THE PRESCRIPTION OR REFERRAL OF A PHYSICIAN.

32 (4) FOR THE PURPOSES OF THIS SUBSECTION, THE NURSE MIDWIFE
33 NEED NOT BE UNDER THE SUPERVISION OF A PHYSICIAN.

34 (5) EXCEPT AS OTHERWISE PROVIDED BY LAW, A CONTRACT THAT THE
35 AUTHORITY MAKES UNDER THIS SUBSECTION SHALL CONTINUE UNLESS
36 TERMINATED UNDER THE TERMS OF THE CONTRACT BY THE PROGRAM OR BY THE
37 PROVIDER.

1 [15-103.1.] 15-1A-06.

2 The Program shall use its leverage as a high volume purchaser to promote the
3 cost effectiveness of Maryland's health care system.

4 [15-104.] 15-1A-07.

5 The [Secretary] AUTHORITY may contract with the Department of Human
6 Resources to provide medical services to those individuals for whom:

7 (1) Funds are appropriated to the Department of Human Resources; and

8 (2) The Department of Human Resources is responsible under the
9 appropriation.

10 [15-105.] 15-1A-08.

11 (a) The [Department] AUTHORITY shall adopt rules and regulations for the
12 reimbursement of providers under the Program. However, except for an invoice that
13 must be submitted to a Medicare intermediary or Medicare carrier for an individual
14 who may have both Medicare and Medicaid coverage, payment may not be made for
15 an invoice that is received more than 1 year after the dates of the services given.

16 (b) A provider who fails to submit an invoice within the required time may not
17 recover the amount later from the Program recipient.

18 (c) (1) The [Department] AUTHORITY shall adopt regulations for the
19 reimbursement of specialty outpatient treatment and diagnostic services rendered to
20 Program recipients at a freestanding clinic owned and operated by a hospital that is
21 under a capitation agreement approved by the Health Services Cost Review
22 Commission.

23 (2) (i) Except as provided in subparagraph (ii) of this paragraph, the
24 reimbursement rate under paragraph (1) of this subsection shall be set according to
25 Medicare standards and principles for retrospective cost reimbursement as described
26 in 42 CFR Part 413 or on the basis of charges, whichever is less.

27 (ii) The reimbursement rate for a hospital that has transferred
28 outpatient oncology, diagnostic, rehabilitative, and digestive disease services to an
29 off-site facility prior to January 1, 1999 shall be set according to the rates approved
30 by the Health Services Cost Review Commission if:

31 1. The transfer of services was due to zoning restrictions at
32 the hospital campus;

33 2. The off-site facility is surveyed as part of the hospital for
34 purposes of accreditation by the Joint Commission on the Accreditation of Health
35 Care Organizations; and

1 3. The hospital notifies the Health Services Cost Review
2 Commission in writing by July 1, 1999 that the hospital would like the services
3 provided at the off-site facility subject to Title 19, Subtitle 2 of this article.

4 (d) This section has no effect if its operation would cause this State to lose any
5 federal funds.

6 [15-106.] 15-1A-09.

7 (a) (1) In cooperation with the professional organizations whose members
8 provide health care under the Program, the [Secretary] AUTHORITY shall establish a
9 system of review for all health care that is provided.

10 (2) The review shall include a study of the quality of care and the proper
11 use of the services by the Program recipient or the provider.

12 (b) A member of an appointed committee of any of these professional
13 organizations or an appointed member of a committee of a medical staff of a licensed
14 hospital shall have the immunity from liability described under § 5-628 of the Courts
15 and Judicial Proceedings Article.

16 [15-107.] 15-1A-10.

17 (a) The [Department] AUTHORITY may require facilities that participate in
18 the Program to submit cost reports, as defined by the [Department] AUTHORITY,
19 within the time set by the [Department] AUTHORITY.

20 (b) If a report is not submitted within that time, the [Department]
21 AUTHORITY shall withhold from the facility up to 10 percent of current interim
22 payments for the calendar month in which the report is due and any later calendar
23 months until the report is submitted.

24 [15-108.] 15-1A-11.

25 (a) In this section, "board" means an appeal board established under this
26 section.

27 (b) (1) The [Secretary] AUTHORITY may:

28 (i) Establish one or more boards for purposes of this section; and

29 (ii) Designate the jurisdiction of a board.

30 (2) A board shall consist of 3 members.

31 (3) Of the 3 board members:

32 (i) 2 shall be appointed by the [Secretary] AUTHORITY; and

33 (ii) 1 shall be chosen by the appointed members.

1 (4) Of the 2 appointed members of a board:

2 (i) 1 shall be a representative of the industry affected who is an
3 individual knowledgeable in Medicare and Medicaid reimbursement principles; and

4 (ii) 1 shall be an individual who is employed by this State and
5 knowledgeable in Medicare and Medicaid reimbursement principles and who does not
6 participate directly in the field verifications.

7 (c) (1) If the [Department] AUTHORITY or an agent of the [Department]
8 AUTHORITY does a field verification of the costs and allowable charges of a facility
9 that participates in the Program, the [Department] AUTHORITY or agent shall notify
10 the facility of the results of the field verification.

11 (2) Within 60 days after the facility receives the notification required
12 under paragraph (1) of this subsection, the [Department] AUTHORITY shall pay the
13 facility the amount the [Department] AUTHORITY has determined is due the facility
14 by the [Department] AUTHORITY regardless of whether or not the facility files an
15 appeal.

16 (d) (1) A facility may appeal the results of a field verification by filing
17 written notice with the appropriate board within 30 days after the facility receives
18 the notice from the [Department] AUTHORITY or its agent.

19 (2) (i) Within 30 days after the filing of an appeal to the board by a
20 facility that the [Department] AUTHORITY has determined owes money to the State,
21 the [Department] AUTHORITY shall recalculate the amount that is due to the State
22 based on the field verification, exclusive of the amount in controversy which is subject
23 to the appeal, and shall notify the facility of that amount.

24 (ii) Subject to the provisions of subparagraphs (iii) and (iv) of this
25 paragraph, payment for the amount due the State, if any, after the recalculation shall
26 be made within 60 days after the facility receives notification of the recalculation.

27 (iii) If a facility requests a longer payment schedule within 60 days
28 after the facility receives notification of the recalculation, the [Department]
29 AUTHORITY may establish, after consultation with the facility, a longer payment
30 schedule.

31 (iv) The [Department] AUTHORITY shall establish a longer
32 payment schedule if, in the [Department's] AUTHORITY'S reasonable judgment,
33 failure to grant a longer payment schedule would:

34 1. Result in financial hardship to the facility; or
35 2. Have an adverse effect on the quality of patient care
36 furnished by the facility.

37 (3) (i) If a facility files an appeal, the portion of the amount in
38 controversy that is actually paid shall be subject to an award of interest that is:

1 1. Calculated from the date the appeal was filed through the
2 date of payment; and

3 2. Determined in accordance with a rate of interest
4 established by regulation.

5 (ii) Interest paid by a facility under subparagraph (i) of this
6 paragraph is not an allowable cost.

7 (iii) Interest paid to a facility under subparagraph (i) of this
8 paragraph is not subject to any offset or other reduction against otherwise allowable
9 costs.

10 (4) If a facility other than a hospital, or if the [Department] AUTHORITY
11 is aggrieved by a final decision of the board under this section, the facility or the
12 [Department] AUTHORITY shall place any money due from the facility or from the
13 [Department] AUTHORITY in an interest bearing escrow account. The money shall
14 remain in escrow until a final decision has been rendered.

15 (5) Upon a final determination of the dispute, the appropriate person
16 administering the escrow account shall distribute the money in that account,
17 including any interest accrued, in conformity with the final determination.

18 (e) (1) After the [Department] AUTHORITY receives the findings of a board,
19 the [Department] AUTHORITY shall determine the amount that is due either to this
20 State or to the facility and notify the facility of that amount.

21 (2) If the facility has accepted the determination made under paragraph
22 (1) of this subsection, within 60 days after the facility receives the notification under
23 paragraph (1) of this subsection the [Department] AUTHORITY shall pay the amount
24 the [Department] AUTHORITY has determined is due the facility, if any.

25 (3) Subject to the provisions of paragraphs (4) and (5) of this subsection,
26 within 60 days after the facility receives notification, the facility shall pay the amount
27 due the [Department] AUTHORITY, if any.

28 (4) If a facility requests a longer payment schedule within 30 days after
29 the facility receives notification of the amount due the [Department] AUTHORITY,
30 the [Department] AUTHORITY may establish, after consultation with the facility, a
31 longer payment schedule.

32 (5) The [Department] AUTHORITY shall establish a longer payment
33 schedule if, in the [Department's] AUTHORITY'S reasonable judgment, failure to
34 grant a longer payment schedule would:

35 (i) Result in financial hardship to the facility; or

36 (ii) Have an adverse effect on the quality of patient care furnished
37 by the facility.

1 (f) (1) The [Department] AUTHORITY or any facility aggrieved by a
2 reimbursement decision of the board under this section may not appeal to the Board
3 of Review but may take a direct judicial appeal.

4 (2) The appeal shall be made as provided for judicial review of final
5 decisions in the Administrative Procedure Act.

6 [15-109.] 15-1A-12.

7 (a) An individual is not ineligible under the Program solely because Social
8 Security benefits received by the individual are increased, unless:

9 (1) The individual is considered ineligible because of the increase under
10 applicable rules or regulations of the United States Department of Health and
11 Human Services; and

12 (2) As to that individual, federal matching funds for the State Program
13 are not available.

14 (b) [Except as provided in § 15-103(a)(2)(ii) of this subtitle, to] TO determine
15 eligibility under the Program, the [Department] AUTHORITY annually shall set the
16 allowable yearly income levels in amounts at least equal to the following:

17 (1) Family of 1 - \$2,500.

18 (2) Family of 2 - \$3,000.

19 (3) Family of 3 - \$3,500.

20 (4) Family of 4 - \$4,000.

21 (5) Family of 5 or more - \$4,500 plus an increase of \$500 for each family
22 member in excess of 5.

23 (c) This section is effective only to the extent that its provisions do not conflict
24 with federal requirements for the administration of the Program in this State.

25 (d) As a condition of eligibility for medical assistance, a recipient is deemed to
26 have assigned to the [Secretary of Health and Mental Hygiene or the Secretary's
27 designee] AUTHORITY any rights to payment for medical care services from any third
28 party who has the legal liability to make payments for those services, to the extent of
29 any payments made by the [Department] AUTHORITY on behalf of the recipient.

30 (e) (1) Each resident of a nursing home who is a recipient of medical
31 assistance shall receive a personal needs allowance.

32 (2) After a determination of income eligibility is made for a nursing
33 home resident under the Program, the personal needs allowance shall be deducted
34 from the total income of the resident.

1 (3) The personal needs allowance for each resident of a nursing home
2 who is a recipient of medical assistance shall be:

3 (i) If on or before June 30, 2002, the federal Centers for Medicare
4 and Medicaid Services approve the Department's application for an amendment to the
5 State's existing § 1115 demonstration waiver necessary to implement the Maryland
6 Pharmacy Discount Program established under [§ 15-124.1 of the Health - General
7 Article] § 15-1A-32 OF THIS ARTICLE:

- 8 1. Beginning April 1, 2003, \$50 per month;
9 2. Beginning July 1, 2004, \$60 per month; and
10 3. Beginning July 1, 2005, adjusted annually by an amount
11 not exceeding 5% to reflect the percentage by which benefits under Title II of the
12 Social Security Act (42 U.S.C. 401 through 433) are increased by the federal
13 government to reflect changes in the cost of living, as that percentage change is
14 reported in the Federal Register in accordance with 42 U.S.C. 415(a)(1)(D); or

15 (ii) If on or before June 30, 2002, the federal Centers for Medicare
16 and Medicaid Services do not approve the Department's application for an
17 amendment to the State's existing § 1115 demonstration waiver necessary to
18 implement the Maryland Pharmacy Discount Program established under § 15-124.1
19 of the Health - General Article:

- 20 1. Beginning July 1, 2003, \$50 per month;
21 2. Beginning July 1, 2004, \$60 per month; and
22 3. Beginning July 1, 2005, adjusted annually by an amount
23 not exceeding 5% to reflect the percentage by which benefits under Title II of the
24 Social Security Act (42 U.S.C. 401 through 433) are increased by the federal
25 government to reflect changes in the cost of living, as that percentage change is
26 reported in the Federal Register in accordance with 42 U.S.C. 415(a)(1)(D).

27 (4) The [Secretary] AUTHORITY shall adopt regulations to implement
28 this subsection.

29 (f) Subject to the confidentiality requirements of State and federal law, the
30 courts of this State shall admit a certified copy of a 206N form, also known as a
31 long-term care transaction form, into evidence.

32 [15-110.] 15-1A-13.

33 The [Department] AUTHORITY shall reimburse acute general and chronic care
34 hospitals that participate in the Program for care provided to Program recipients in
35 accordance with rates that the Health Services Cost Review Commission approves
36 under Title 19, Subtitle 2 of this article, if the United States Department of Health
37 and Human Services approves this method of reimbursement.

1 [15-111.] 15-1A-14.

2 (a) The [Department] AUTHORITY may authorize reimbursement of a
3 licensed day care center for the elderly or medically handicapped adults for medical
4 care that the center provides to a Program recipient who is certified as requiring
5 nursing home care.

6 (b) (1) Reimbursement under this section is subject to the availability of
7 federal funds.

8 (2) The reimbursement rate for medical day care:

9 (i) May not exceed a maximum per diem rate established by
10 regulation of the [Department] AUTHORITY; and

11 (ii) Shall cover the following:

- 12 1. Administrative overhead;
- 13 2. Drugs, supplies, and equipment;
- 14 3. Food;
- 15 4. Medical services;
- 16 5. Staff; and
- 17 6. Transportation.

18 [15-112.] 15-1A-15.

19 After consultation with the State Board of Pharmacy, the [Secretary]
20 AUTHORITY may authorize reimbursement of a physician for the dispensing of drugs
21 to Program recipients, on the same basis as a licensed pharmacist if:

22 (1) The physician dispenses drugs on a regular basis in the physician's
23 office; and

24 (2) There is no pharmacy within 10 miles of that office.

25 [15-113.] 15-1A-16.

26 (a) In this section, "inmate of a public institution" has the meaning stated in
27 Title 42, § 435.1009 of the Code of Federal Regulations (1978 edition).

28 (b) (1) If an inmate of a public institution is eligible for federally funded
29 Medicaid benefits, the [Department] AUTHORITY shall pay the custodial authority
30 for any medical care that is provided to the inmate during the month when the
31 individual became an inmate.

1 (2) Payments under this subsection shall be made in accordance with
2 applicable rules and regulations for the Program.

3 (c) The [Department] AUTHORITY shall be reimbursed for the nonfederal cost
4 of medical care by either the State or local authority that is responsible for the inmate
5 of a public institution.

6 [15-114.] 15-1A-17.

7 (a) In this section, "related institution" includes any of the following facilities,
8 as classified from time to time by law, rule, or regulation:

9 (1) A comprehensive care facility.

10 (2) An extended care facility.

11 (3) An intermediate care facility.

12 (4) A skilled nursing facility.

13 (b) This section applies only to the extent that federal funds are available for
14 reimbursement under this section.

15 (c) In accordance with subsection (e) of this section, the [Department]
16 AUTHORITY shall reimburse each hospital-based related institution that:

17 (1) Is a distinct part of an acute or chronic hospital; and

18 (2) On and after July 1, 1980, is licensed as a related institution.

19 (d) (1) The Health Services Cost Review Commission shall determine rates
20 for fiscal years 1986, 1987, 1988, and 1989 for purposes of the reimbursement formula
21 established under subsection (e) of this section and shall inform the [Department]
22 AUTHORITY of the reimbursement rates prior to the beginning of the respective fiscal
23 year.

24 (2) The rates determined by the Health Services Cost Review
25 Commission under this section shall be the rates that would have been in effect
26 during the respective fiscal year if the hospital-based related institution had
27 remained under the full rate jurisdiction of the Health Services Cost Review
28 Commission.

29 (e) The reimbursement required by this section shall be in accordance with
30 the following formula:

31 (1) For the period from July 1, 1985 through June 30, 1986, a per diem
32 rate calculated as the sum of:

33 (i) 80% of the rate determined by the Health Services Cost Review
34 Commission under subsection (d) of this section; and

1 (ii) 20% of the per diem rate of the hospital-based related
2 institution determined under the Program regulations applicable to skilled and
3 intermediate care nursing facilities.

4 (2) For the period from July 1, 1986 through June 30, 1987, a per diem
5 rate calculated as the sum of:

6 (i) 60% of the rate determined by the Health Services Cost Review
7 Commission under subsection (d) of this section; and

8 (ii) 40% of the per diem rate of the hospital-based related
9 institution determined under the Program regulations applicable to skilled and
10 intermediate care nursing facilities.

11 (3) For the period from July 1, 1987 through June 30, 1988, a per diem
12 rate calculated as the sum of:

13 (i) 40% of the rate determined by the Health Services Cost Review
14 Commission under subsection (d) of this section; and

15 (ii) 60% of the per diem rate of the hospital-based related
16 institution determined under the Program regulations applicable to skilled and
17 intermediate care nursing facilities.

18 (4) For the period from July 1, 1988 through June 30, 1989, a per diem
19 rate calculated as the sum of:

20 (i) 20% of the rate determined by the Health Services Cost Review
21 Commission under subsection (d) of this section; and

22 (ii) 80% of the per diem rate of the hospital-based related
23 institution determined under the Program regulations applicable to skilled and
24 intermediate care nursing facilities.

25 (5) [Beginning July 1, 1989, the Department] THE AUTHORITY shall
26 reimburse at rates determined under the Program regulations applicable to skilled
27 and intermediate care nursing facilities.

28 [15-114.1.] 15-1A-18.

29 (a) In this section, "emergency service transporter" means a public entity or
30 volunteer fire, rescue, or emergency medical service that provides emergency medical
31 services.

32 (b) If an emergency service transporter charges for its services and requests
33 reimbursement from the Program, the [Department] AUTHORITY shall reimburse
34 the emergency service transporter, in an amount not to exceed \$100 per transport, for
35 the cost of:

1 (1) Transportation the emergency service transporter provides to a
2 Program recipient to a facility in response to a 911 call; and

3 (2) Medical services the emergency service transporter provides to the
4 Program recipient while transporting the Program recipient to a facility in response
5 to a 911 call.

6 (c) The [Department] AUTHORITY shall adopt any regulations necessary to
7 carry out this section.

8 [15-115.] 15-1A-19.

9 (a) The [Department] AUTHORITY may not place a Program recipient in a
10 skilled or intermediate nursing facility if, because of the condition of the Program
11 recipient, the placement would cause undue risk to the Program recipient.

12 (b) To provide a basis for evaluating the placement of Program recipients who
13 need skilled or intermediate nursing care in skilled or intermediate nursing facilities,
14 a Program recipient may be placed only in a nursing facility that has a transfer
15 agreement with a general hospital.

16 [15-116.] 15-1A-20.

17 The [Department] AUTHORITY shall reimburse skilled nursing facilities for
18 services provided to indigent or medically indigent patients under the age of 21 years.
19 [15-117.] 15-1A-21.

20 (a) In this section, "leave of absence" includes:

21 (1) A visit with friends or relatives; and

22 (2) A leave to participate in a State approved therapeutic or
23 rehabilitative program.

24 (b) (1) To ensure that a bed is reserved for a Program recipient who is
25 absent temporarily from a nursing facility, the Program shall include the following
26 payments for nursing facilities that have made a provider agreement with the
27 [Department] AUTHORITY.

28 (2) If the Program recipient is absent from a nursing facility due to
29 hospitalization for an acute condition, the facility shall receive payment for each day
30 that the Program recipient is hospitalized and a bed is reserved and made available
31 for the return of that Program recipient.

32 (3) If a Program recipient is on leave of absence from a nursing facility,
33 the facility shall receive payment for each day that the Program recipient is absent
34 and a bed is reserved and made available for the return of that Program recipient.

35 (c) (1) Payments under subsection (b)(2) of this section may not be made for
36 more than 15 days for any single hospital stay.

1 (2) (i) Payments under subsection (b)(3) of this section may not be
2 made for more than 18 days in any calendar year.

3 (ii) Notwithstanding any rule or regulation, a leave of absence is
4 not subject to any requirement that it may not exceed a particular number of days a
5 visit, except that the leave of absence may not exceed a total of 18 days during any
6 12-month period.

7 (d) Payments required under this section shall be made according to the per
8 diem payment procedures that the [Department] AUTHORITY sets and may not be
9 less than the per diem payments made to the nursing facility for days when the
10 Program recipient is present in the facility.

11 (e) A nursing facility may not make additional charges against a Program
12 recipient because the Program recipient is absent temporarily from the nursing
13 facility.

14 [15-118.] 15-1A-22.

15 (a) (1) Unless the prescriber directs otherwise on the form or on an attached
16 signed certification of need, the generic form of the drug authorized under § 12-504 of
17 the Health Occupations Article shall be used to fill the prescription.

18 (2) If the appropriate generic drug is not generally available, the
19 [Department] AUTHORITY may waive the requirement for generic substitution under
20 paragraph (1) of this subsection.

21 (b) (1) Except as provided under paragraph (2) of this subsection, the
22 Program shall establish maximum reimbursement levels for the drug products for
23 which there is a generic equivalent authorized under § 12-504 of the Health
24 Occupations Article, based on the cost of the generic product.

25 (2) If a prescriber directs a specific brand name drug, the reimbursement
26 level shall be based on the cost of the brand name product.

27 (c) (1) Except as provided under paragraph (4) of this subsection and unless
28 the change is made by an emergency regulation, the Program shall notify all
29 pharmacies under contract with the Program in writing of changes in the
30 Pharmaceutical Benefit Program rules or requirements at least 30 days before the
31 change is effective.

32 (2) Changes that require 30 days' advance written notice under
33 paragraph (1) of this subsection are:

34 (i) Exclusion of coverage for classes of drugs as specified by
35 contract;

36 (ii) Changes in prior or preauthorization procedures; and

37 (iii) Selection of new prescription claims processors.

1 (3) If the Program fails to provide advance notice as required under
2 paragraph (1) of this subsection, it shall honor and pay in full any claim under the
3 Program rules or requirements that existed before the change for 30 days after the
4 postmarked date of the notice.

5 (4) Notwithstanding any other provision of law, the notice requirements
6 of this subsection do not apply to the addition of new generic drugs authorized under
7 § 12-504 of the Health Occupations Article.

8 (d) The [Secretary] AUTHORITY shall adopt regulations to carry out the
9 provisions of this section.

10 [15-120.] 15-1A-23.

11 (a) If a Program recipient has a cause of action against a person, the
12 [Department] AUTHORITY shall be subrogated to that cause of action to the extent of
13 any payments made by the [Department] AUTHORITY on behalf of the Program
14 recipient that result from the occurrence that gave rise to the cause of action.

15 (b) (1) An attorney representing a Program recipient in a cause of action to
16 which the [Department] AUTHORITY has a right of subrogation shall notify the
17 [Department] AUTHORITY prior to filing a claim, commencing an action, or
18 negotiating a settlement.

19 (2) The attorney shall notify the [Department] AUTHORITY in advance
20 of the resolution of a cause of action and shall allow the [Department] AUTHORITY 3
21 business days from the receipt of the notice to establish its subrogated interest.

22 (3) This subsection may not be construed to create a cause of action for
23 notifying or failing to notify the [Department] AUTHORITY.

24 (c) (1) Any Program recipient or attorney, guardian, or personal
25 representative of a Program recipient who receives money in settlement of or under a
26 judgment or award in a cause of action in which the [Department] AUTHORITY has a
27 subrogation claim shall, after receiving written notice of the subrogation claim, hold
28 that money, for the benefit of the [Department] AUTHORITY, to the extent required
29 for the subrogation claim, after deducting applicable attorney fees and litigation
30 costs.

31 (2) A person who, after written notice of a subrogation claim and possible
32 liability under this paragraph, disposes of the money, without the written approval of
33 the [Department] AUTHORITY, is liable to the [Department] AUTHORITY for any
34 amount that, because of the disposition, is not recoverable by the [Department]
35 AUTHORITY.

36 (3) The [Department] AUTHORITY may compromise or settle and
37 release its subrogation claim if, in its judgment, collection of the claim will cause
38 substantial hardship:

39 (i) To the Program recipient; or

1 (ii) In a wrongful death action, to the surviving dependents of a
2 deceased Program recipient.

3 (4) (i) The [Department] AUTHORITY is not liable for payment of or
4 contribution to any attorney fees or litigation costs of any Program recipient or
5 attorney, guardian, or personal representative of any Program recipient.

6 (ii) The deduction of applicable attorney fees and litigation costs
7 under paragraph (1) of this subsection may not be considered as payment for or
8 contribution to those fees or costs by the [Department] AUTHORITY.

9 (d) Any action brought under this section is not exclusive and is independent
10 of and in addition to any right, remedy, or cause of action available to the State, the
11 [Department] AUTHORITY, any other State agency, or a Program recipient or any
12 other individual.

13 (e) (1) (i) In this subsection[,] the following words have the meanings
14 indicated.

15 (ii) "Cigarette" means any roll of tobacco wrapped in:

16 1. Paper;

17 2. A substance not containing tobacco; or

18 3. A substance containing tobacco which because of its
19 appearance, the type of tobacco used in the filler, or its packaging and labeling, is
20 likely to be used by the consumers of ordinary paper-wrapped cigarettes.

21 (iii) 1. "Manufacturer of a tobacco product" means a designer,
22 producer, or processor of a tobacco product engaged in the marketing or promotion of
23 a tobacco product.

24 2. "Manufacturer of a tobacco product" includes an entity not
25 otherwise a manufacturer of a tobacco product that imports a tobacco product or
26 otherwise holds itself out as a manufacturer of a tobacco product.

27 3. "Manufacturer of a tobacco product" does not include:

28 A. A grower, buyer, dealer, distributor, or wholesaler of leaf
29 tobacco; or

30 B. A retailer, distributor, or wholesaler of a tobacco product.

31 (iv) "Smokeless tobacco" means a product that consists of cut,
32 ground, powdered, or leaf tobacco that is intended to be placed in the oral cavity.

33 (v) "Tobacco product" means cigarettes or smokeless tobacco.

34 (2) In any action under this section or pursuant to any other right,
35 remedy, or cause of action brought by the State against a manufacturer of a tobacco

1 product, the causation and the amount of medical assistance expenditures
2 attributable to the use of a tobacco product may be proved or disproved by evidence of
3 statistical analysis, without proof of the causation or the amount of expenditures for
4 any particular Program recipient or any other individual.

5 (3) Nothing contained in paragraph (2) of this subsection prohibits or
6 limits the right of any party to introduce any other evidence, otherwise admissible,
7 that supports or rebuts the evidence of statistical analysis described in paragraph (2)
8 of this subsection.

9 [15-121.] 15-1A-24.

10 (a) In accordance with applicable federal law and rules and regulations,
11 including those under Title XIX of the Social Security Act, the [Department]
12 AUTHORITY may make claim against the estate of a deceased Program recipient for
13 the amount of any medical assistance payments under this title.

14 (b) The claim shall be waived by the [Department] AUTHORITY if, in its
15 judgment, enforcement of the claim will cause substantial hardship to the surviving
16 dependents of the deceased.

17 [15-121.1.] 15-1A-25.

18 (a) If a Program recipient has a claim for any medical, hospital or disability
19 benefits under §§ 19-505 and 19-506 of the Insurance Article, the [Department]
20 AUTHORITY shall be subrogated to that claim to the extent of any payments made by
21 the [Department] AUTHORITY on behalf of the Program recipient that results from
22 the occurrence that gave rise to the claim less:

23 (1) Applicable attorney's fees; and

24 (2) Any rights for loss of income.

25 (b) (1) An attorney representing a Program recipient under this subtitle on
26 a claim to which the [Department] AUTHORITY has a right of subrogation shall notify
27 the [Department] AUTHORITY prior to filing the claim.

28 (2) This subsection may not be construed to create a cause of action for
29 notifying or failing to notify the [Department] AUTHORITY.

30 (c) (1) Any Program recipient or attorney, guardian, or personal
31 representative of a Program recipient who receives money for a claim to which the
32 [Department] AUTHORITY has a subrogation claim shall, after receiving written
33 notice of the subrogation claim, hold that money, for the benefit of the [Department]
34 AUTHORITY, to the extent required for the subrogation claim, after deducting
35 applicable attorney's fees.

36 (2) A person who, after written notice of a subrogation claim from the
37 [Department] AUTHORITY and possible liability under this paragraph, disposes of
38 the money, without the written approval of the [Department] AUTHORITY, is liable to

1 the [Department] AUTHORITY for any amount that, because of the disposition, is not
2 recoverable by the [Department] AUTHORITY.

3 (3) The [Department] AUTHORITY may compromise or settle and
4 release its subrogation claim if, in its judgment, collection of the claim will cause
5 substantial hardship to the Program recipient or in a wrongful death action, the
6 surviving dependent of a deceased Program recipient.

7 [15-121.2.] 15-1A-26.

8 (a) If a Program recipient has a claim for any medical, hospital, or disability
9 benefits under §§ 19-509 and 19-510 of the Insurance Article, the [Department]
10 AUTHORITY shall be subrogated to that claim to the extent of any payments made by
11 the [Department] AUTHORITY on behalf of the Program recipient that results from
12 the occurrence that gave rise to the claim, less applicable attorney's fees.

13 (b) (1) An attorney representing a Program recipient under this subtitle on
14 a claim to which the [Department] AUTHORITY has a right of subrogation shall notify
15 the [Department] AUTHORITY prior to filing the claim.

16 (2) This subsection may not be construed to create a cause of action for
17 notifying or failing to notify the [Department] AUTHORITY.

18 (c) (1) Any Program recipient, attorney, guardian, or personal
19 representative of a Program recipient who receives money for a claim to which the
20 [Department] AUTHORITY has a subrogation claim shall, after receiving written
21 notice of the subrogation claim, hold that money, for the benefit of the [Department]
22 AUTHORITY, to the extent required for the subrogation claim, after deducting
23 applicable attorney's fees.

24 (2) A person who, after written notice of a subrogation claim from the
25 [Department] AUTHORITY and possible liability under this paragraph, disposes of
26 the money, without the written approval of the [Department] AUTHORITY, is liable to
27 the [Department] AUTHORITY for any amount that, because of the disposition, is not
28 recoverable by the [Department] AUTHORITY.

29 (3) The [Department] AUTHORITY may compromise or settle and
30 release its subrogation claim if, in its judgment, collection of the claim will cause
31 substantial hardship to the Program recipient or in a wrongful death action, the
32 surviving dependent of a deceased Program recipient.

33 [15-122.] 15-1A-27.

34 (a) (1) The spouse of a Program recipient is responsible for payments for the
35 health care needs of the Program recipient to the extent that the spouse is able to pay
36 any of the cost of care. Except as provided in paragraph (2) of this subsection, the total
37 liability shall be limited to the amount spent for the care under the Program.

38 (2) In any case in which eligibility was based on the spouse's refusal to
39 pay for the Program recipient's care, the liability of the spouse may include:

- 1 (i) The amount spent for care by the Program;
- 2 (ii) Administrative and enforcement costs incurred by the Program
3 related to pursuing reimbursement from the spouse; and
- 4 (iii) Any penalties established by the [Secretary] AUTHORITY by
5 regulation for a violation of this section not to exceed \$50 per day for each day a
6 violation exists.

7 (b) (1) The [Secretary] AUTHORITY shall adopt rules and regulations that
8 set standards for payment by the spouse based on the ability of the spouse to pay all
9 or part of the cost of care. To determine reasonably the ability to pay, the [Secretary]
10 AUTHORITY shall evaluate available income, ordinary living expenses, special
11 expenses, and assets, other than the homestead of the spouse and its appurtenances.

12 (2) Notwithstanding the standards established under paragraph (1) of
13 this subsection, the spouse may also be liable for costs and penalties under subsection
14 (a)(2) of this section.

15 (c) (1) The [Secretary] AUTHORITY may collect the money owed.

16 (2) The central collection unit in the Department of Budget and
17 Management shall collect delinquent accounts and debts.

18 [15-122.1.] 15-1A-28.

19 (a) In this section, "participating provider" means any facility that
20 participates in the Program and is:

- 21 (1) A skilled nursing facility;
- 22 (2) A comprehensive care facility; or
- 23 (3) An intermediate care facility.

24 (b) A participating provider shall not be required to repay the State for any
25 depreciation for which the provider has been reimbursed as an allowable expense and
26 which could otherwise be recaptured by the State upon a sale, scrapping, trade-in,
27 donation, exchange, demolition, or abandonment of a facility, or involuntary
28 conversion of a facility such as condemnation, fire, theft, or other casualty.

29 (c) This section has no effect if its operation would cause this State to lose any
30 federal funds.

31 [15-122.2.] 15-1A-29.

32 (a) In this section, "converted funds" means the amount received in payment
33 by a person from an insurer for the cost of health services provided to a child which
34 was not used to reimburse the [Department] AUTHORITY for Medicaid costs
35 incurred.

1 (b) Each year the [Department] AUTHORITY may refer to the Central
2 Collection Unit of the Department of Budget and Management for certification to the
3 State Comptroller the name of any person who has received converted funds for the
4 interception of any State tax refund.

5 (c) The [Department] AUTHORITY shall notify the person certified under
6 subsection (b) of this section that a certification has been made by the [Department]
7 AUTHORITY.

8 (d) The certification by the Central Collection Unit shall include, if known:

9 (1) The full name of the person certified and any other names known to
10 be used by that person;

11 (2) The address and the Social Security number of the person certified;
12 and

13 (3) The amount of the converted funds.

14 (e) The State Comptroller shall:

15 (1) Pay to the [Department] AUTHORITY any income tax refund due to
16 the person certified in an amount not more than the amount certified by the
17 [Department] AUTHORITY;

18 (2) Pay to the person certified any part of the income tax refund over the
19 amount of the converted funds; and

20 (3) Notify the person certified of:

21 (i) The amount paid to the [Department] AUTHORITY; and

22 (ii) The rights of the person certified under subsection (b) of this
23 section.

24 (f) (1) On receipt of a notice of intercept from the State Comptroller, any
25 person certified by the [Department] AUTHORITY who disputes the existence or
26 amount of the converted funds may file an appeal in accordance with Title 10 of the
27 State Government Article.

28 (2) If the [Department] AUTHORITY finds that an excessive amount was
29 withheld from the person's income tax refund, the [Department] AUTHORITY
30 promptly shall pay to the taxpayer the excess amount withheld.

31 (g) The Comptroller shall honor refund interception requests in the following
32 order:

33 (1) A refund interception request to collect an unpaid State, county, or
34 municipal tax;

1 (2) A refund interception request under § 10-113 of the Family Law
2 Article for arrears of support payments;

3 (3) A refund interception request for converted funds under this subtitle;
4 and

5 (4) Any other refund interception request.

6 (h) The [Secretary] AUTHORITY and the State Comptroller may adopt
7 regulations to carry out this section.

8 [15-123.] 15-1A-30.

9 (a) (1) In this section the following words have the meanings indicated.

10 (2) "Convicted" includes being convicted after a plea of nolo contendere.

11 (3) "Fraud" includes the commission of or an attempt or conspiracy to
12 commit the crimes of:

13 (i) Concealment of medical records;

14 (ii) Violation of Title 8, Subtitle 5, Part II of the Criminal Law
15 Article;

16 (iii) False representations relating to Medicaid health plans;

17 (iv) Misappropriation by a fiduciary; and

18 (v) Theft.

19 (b) A health care provider who is convicted of fraud in connection with the
20 Program or a similar federal or State program is ineligible for further payment under
21 the Program.

22 [15-124.] 15-1A-31.

23 (a) (1) The [Department] AUTHORITY shall maintain a Maryland Pharmacy
24 Assistance Program for low income individuals whose:

25 (i) Assets are not more than 1.5 times the amount of accountable
26 resources according to the asset schedule of the Maryland Medical Assistance
27 Program; and

28 (ii) Gross annual income does not exceed:

29 1. \$4,600 plus \$500 for each individual over 1 in a family
30 unit; and

31 2. An annual increase set by the [Secretary] AUTHORITY
32 under paragraph (2)(ii)4 of this subsection.

1 (2) (i) 1. In this paragraph the following words have the meanings
2 indicated.

3 2. "Income disregard" means the exclusion of up to \$1,000 of
4 annual income earned by an individual as a client of a sheltered workshop if the
5 individual's sole other income is derived from a Social Security payment.

6 3. "Sheltered workshop" means a workshop licensed by the
7 Developmental Disabilities Administration under Title 7, Subtitle 9 of this article.

8 (ii) For the purpose of paragraph (1) of this subsection, the
9 [Secretary] AUTHORITY shall:

10 1. In order to determine eligibility for the Maryland
11 Pharmacy Assistance Program, deduct any income disregards from the countable
12 gross income of a unit that contains a disabled individual;

13 2. Define excluded assets;

14 3. Establish a family unit structure; and

15 4. Beginning July 1, 1985, increase annually at the time
16 Social Security benefits are increased, rounded to the next highest even \$50 level, the
17 income level within which an individual is eligible for benefits under the Maryland
18 Pharmacy Assistance Program by the larger of:

19 A. The percentage by which benefits under Title II of the
20 Social Security Act (42 U.S.C. 401-433) are increased by the federal government due
21 to cost-of-living changes as that percentage is reported in the Federal Register
22 pursuant to 42 U.S.C. 415(I)(2)(D) but not to exceed 8 percent; or

23 B. The dollar amount by which the medical assistance income
24 schedules are increased by the State.

25 (b) (1) (i) Reimbursement under the Maryland Pharmacy Assistance
26 Program may be limited to maintenance drugs, anti-infectives, and AZT as specified
27 in regulations to be issued by the Secretary after consultation with the Maryland
28 Pharmacists Association.

29 (ii) 1. For any drug on the Program's interchangeable drug list,
30 the Program shall reimburse providers in an amount not more than it would
31 reimburse for the drug's generic equivalent, unless the individual's physician states,
32 in his or her own handwriting, on the face of the prescription, that a specific brand is
33 "medically necessary" for the particular patient.

34 2. If an appropriate generic drug is not generally available,
35 the [Department] AUTHORITY may waive the reimbursement requirement under
36 sub-subparagraph 1 of this subparagraph.

1 (2) The reimbursement shall be up to the amount paid for the same
2 items or services under the pharmacy program of the Maryland Medical Assistance
3 Program and shall be subject to a copayment of not more than \$5.00 for each covered
4 item or service.

5 (c) (1) Except as provided under paragraph (4) of this subsection and unless
6 the change is made by an emergency regulation, the Maryland Pharmacy Assistance
7 Program shall notify all pharmacies under contract with the Program in writing of
8 changes in the Pharmaceutical Benefit Program rules or requirements at least 30
9 days before the change is effective.

10 (2) Changes that require 30 days' advance written notice under
11 paragraph (1) of this subsection are:

12 (i) Exclusion of coverage for classes of drugs as specified by
13 contract;

14 (ii) Changes in prior or preauthorization procedures; and

15 (iii) Selection of new prescription claims processors.

16 (3) If the Maryland Pharmacy Assistance Program fails to provide
17 advance notice as required under paragraph (1) of this subsection, it shall honor and
18 pay in full any claim under the Program rules or requirements that existed before the
19 change for 30 days after the postmarked date of the notice.

20 (4) Notwithstanding any other provision of law, the notice requirements
21 of this subsection do not apply to the addition of new generic drugs authorized under
22 § 12-504 of the Health Occupations Article.

23 (d) (1) The [Secretary] AUTHORITY shall adopt rules and regulations that
24 authorize the denial, restriction, or termination of eligibility for recipients who have
25 abused benefits under the Maryland Pharmacy Assistance Program.

26 (2) As a condition of participation, the [Department] AUTHORITY may
27 require Maryland Pharmacy Assistance Program participants to apply for eligibility
28 in the Maryland Medical Assistance Program within 60 days of notification to do so by
29 the [Department] AUTHORITY.

30 (3) The rules and regulations shall require that the recipient be given
31 notice and an opportunity for a hearing before eligibility may be denied, restricted, or
32 terminated under this subsection.

33 (e) The [Secretary] AUTHORITY shall develop a program, in consultation with
34 appropriate agencies, that will provide information to ineligible Maryland Pharmacy
35 Assistance Program applicants regarding other programs that they may be eligible
36 for including the Maryland Medbank Program established under [§ 15-124.2] §
37 15-1A-33 of this subtitle [and the short-term prescription drug subsidy plan
38 established under Subtitle 6 of this title].

1 [15-124.1.] 15-1A-32.

2 (a) (1) In this section the following words have the meanings indicated:

3 (2) "Enrollee" means an individual who is enrolled in the Maryland
4 Pharmacy Discount Program.

5 (3) "Program" means the Maryland Pharmacy Discount Program
6 established under this section.

7 (b) There is a Maryland Pharmacy Discount Program within the Maryland
8 Medical Assistance Program.

9 (c) The purpose of the Program is to improve the health status of Medicare
10 beneficiaries who lack prescription drug coverage by providing access to lower cost,
11 medically necessary, prescription drugs.

12 (d) The Program shall be administered and operated by the [Department]
13 AUTHORITY as permitted by federal law or waiver.

14 (e) (1) The Program shall be open to Medicare beneficiaries who lack other
15 public or private prescription drug coverage.

16 (2) Notwithstanding paragraph (1) of this subsection, enrollment in the
17 Maryland Medbank Program established under [§ 15-124.2] § 15-1A-33 of this
18 subtitle or the Maryland Pharmacy Assistance Program established under [§
19 15-124] § 15-1A-31 of this subtitle does not disqualify an individual from being
20 eligible for the Program.

21 (f) (1) Subject to subsection (g) of this section, an enrollee may purchase
22 medically necessary prescription drugs that are covered under the Maryland Medical
23 Assistance Program from any pharmacy that participates in the Maryland Medical
24 Assistance Program at a price that is based on the price paid by the Maryland
25 Medical Assistance Program, minus the aggregate value of any federally mandated
26 manufacturers' rebates.

27 (2) Subject to subsection (g) of this section, and to the extent authorized
28 under federal waiver, an enrollee whose annual household income is at or below 175
29 percent of the federal poverty guidelines may receive a discount subsidized by the
30 [Department] AUTHORITY that is equal to 35 percent of the price paid by the
31 Maryland Medical Assistance Program for each medically necessary prescription drug
32 purchased under the Program.

33 (g) The [Department] AUTHORITY may establish mechanisms to:

34 (1) Recover the administrative costs of the Program;

35 (2) Reimburse participating pharmacies in an amount equal to the
36 Maryland Medical Assistance price, minus the copayment paid by the enrollee for
37 each prescription filled under the Program; and

1 (3) Allow participating pharmacies to collect a \$1 processing fee, in
2 addition to any authorized dispensing fee, for each prescription filled for an enrollee
3 under the Program.

4 (h) The [Secretary] AUTHORITY shall adopt regulations to implement the
5 Program.

6 [15-124.2.] 15-1A-33.

7 (a) (1) In this section the following words have the meanings indicated.

8 (2) "Foundation" means the Maryland Health Care Foundation
9 established under § 20-502 of this article.

10 (3) "Program" means the Maryland Medbank Program established under
11 this section.

12 (b) There is a Maryland Medbank Program.

13 (c) The purpose of the Program is to improve the health status of individuals
14 throughout the State who lack prescription drug coverage by providing access to
15 medically necessary prescription drugs through patient assistance programs
16 sponsored by pharmaceutical drug manufacturers.

17 (d) (1) Subject to paragraph (2) of this subsection, the Program shall be
18 administered by the Foundation.

19 (2) The Foundation shall contract with one or more government or
20 nonprofit entities to operate the Program.

21 (e) (1) The administration and operation of the Program shall be funded
22 through a grant provided by the [Department] AUTHORITY.

23 (2) Program funds may be used in part to purchase interim supplies of
24 prescription drugs for enrollees who have applied to participate in a manufacturer's
25 patient assistance program but have not yet received the approved prescription drug.

26 (f) (1) The Foundation shall ensure that the Program is available to
27 residents in each of the following geographic regions of the State:

28 (i) Western Maryland;

29 (ii) The Eastern Shore;

30 (iii) The Baltimore metropolitan area;

31 (iv) The Maryland counties in the Washington, D.C. metropolitan
32 area; and

33 (v) Southern Maryland, including Anne Arundel County.

1 (2) The Foundation shall use Medbank of Maryland, Inc. and the
2 Western Maryland Prescription Program as the regional offices for the Baltimore
3 metropolitan area and Western Maryland, respectively.

4 (g) Eligibility for the Program shall be limited only by the criteria established
5 by pharmaceutical manufacturers for their patient assistance programs.

6 (h) (1) The Foundation shall require detailed financial reports at least
7 quarterly from the entities that operate the Program.

8 (2) The Foundation shall release funds to the entities that operate the
9 Program as needed and justified by the quarterly reports filed in accordance with
10 paragraph (1) of this subsection.

11 (i) On or before December 1, 2001, and annually thereafter, the Foundation
12 shall report to the Governor and, in accordance with § 2-1246 of the State
13 Government Article, to the General Assembly, on the status of the Maryland Medbank
14 Program established under this section, including:

15 (1) The number and demographic characteristics of the State residents
16 served by the Program;

17 (2) The types and retail value of prescription drugs accessed through the
18 Program;

19 (3) The nature and extent of outreach performed to inform State
20 residents of the assistance available through the Program; and

21 (4) The total volume and retail value of each brand name drug, by
22 manufacturer, accessed through the Program.

23 [15-125.] 15-1A-34.

24 (a) The [Department] AUTHORITY is the agency of this State:

25 (1) To administer a program of services for children who are crippled or
26 who have conditions that lead to crippling; and

27 (2) To supervise the administration of the program services that the
28 [Department] AUTHORITY does not provide directly.

29 (b) The purposes of this program are:

30 (1) To develop, extend, and improve services for finding these children;

31 (2) To provide medical, surgical, corrective, and other services and care;
32 and

33 (3) To provide facilities for diagnosis, hospitalization, and aftercare.

34 (c) The [Department] AUTHORITY may:

- 1 (1) Prepare and administer detailed plans for these purposes;
- 2 (2) Adopt rules and regulations for administering these plans;
- 3 (3) Receive and, in accordance with these plans, spend all funds made
4 available to the [Department] AUTHORITY for these purposes; and
- 5 (4) Cooperate with the federal government in extending and improving
6 these services and in administering these plans.

7 [15-126.] 15-1A-35.

8 The [Secretary] AUTHORITY shall provide educational programs to meet the
9 needs of each physically or mentally handicapped child in the custody of the
10 [Department] AUTHORITY. The cost for each child shall be included and identified in
11 the budget of the [Department] AUTHORITY as submitted to the General Assembly
12 by the Governor.

13 [15-127.] 15-1A-36.

- 14 (a) In this section the following words have the meanings indicated.
- 15 (1) "Child" means any individual under the age of 18 years.
 - 16 (2) "Initial assessment" includes:
 - 17 (i) A psychological evaluation;
 - 18 (ii) Parental interview; and
 - 19 (iii) Medical evaluation.
 - 20 (3) (i) For purposes of this section, "sexual abuse" means any act that
21 involves sexual molestation or exploitation of a child whether or not the sexual
22 molestation or exploitation of the child is by a parent or other person who has
23 permanent or temporary care or custody or responsibility for supervision of a child, or
24 by any household or family member.
 - 25 (ii) "Sexual abuse" includes:
 - 26 1. Incest, rape, or sexual offense in any degree;
 - 27 2. Sodomy; and
 - 28 3. Unnatural or perverted sexual practices.
- 29 (b) If a physician or a hospital provides any of the services described in
30 subsection (c) of this section to a victim of an alleged rape or sexual offense or a victim
31 of alleged child sexual abuse, the services shall be provided without charge to the
32 individual and the physician or hospital is entitled to be paid by the [Department]
33 AUTHORITY for the costs of providing the services.

1 (c) The services to which this section applies are:

2 (1) A physical examination to gather information and evidence as to the
3 alleged crime;

4 (2) Emergency hospital treatment and follow-up medical testing for up
5 to 90 days after the initial physical examination in paragraph (1) of this subsection;
6 and

7 (3) For up to 5 hours of professional time to gather information and
8 evidence as to the alleged sexual abuse, an initial assessment of a victim of alleged
9 child sexual abuse by:

10 (i) A physician;

11 (ii) Qualified hospital health care personnel;

12 (iii) A mental health professional; or

13 (iv) An interdisciplinary team expert in the field of child abuse.

14 (d) (1) A physician who examines a victim of alleged child sexual abuse
15 under the provisions of this section is immune from any civil liability that may result
16 from the failure of the physician to obtain consent from the child's parent, guardian,
17 or custodian for the examination or treatment of the child.

18 (2) The immunity extends to:

19 (i) Any hospital with which the physician is affiliated or to which
20 the child is brought; and

21 (ii) Any individual working under the control or supervision of the
22 hospital.

23 [15-128.] 15-1A-37.

24 The [Department] AUTHORITY may provide reimbursement, under the
25 Maryland Medical Assistance Program, for services provided by a hospice care
26 program, as defined in § 19-901 of this article.

27 [15-129.] 15-1A-38.

28 (a) In this section "durable medical equipment" means durable medical
29 equipment listed in the medical assistance provider fee manual, as provided in
30 regulations adopted by the [Department] AUTHORITY.

31 (b) To determine whether the prices charged for durable medical equipment
32 provided to Program recipients are reasonable, the [Department] AUTHORITY shall
33 establish regulations and procedures for reviewing the prices of durable medical
34 equipment every 3 years.

1 (c) The [Department] AUTHORITY, to the extent feasible and appropriate,
2 shall recover all durable medical equipment from Program recipients that:

3 (1) Was purchased by the [Department] AUTHORITY; and

4 (2) Is no longer required by the recipient.

5 (d) Except as provided in subsection (e) of this section and to the extent
6 feasible and appropriate, the [Department] AUTHORITY shall reuse the durable
7 medical equipment recovered under subsection (c) of this section to meet the needs of
8 other Program recipients for the same durable medical equipment.

9 (e) If the durable medical equipment recovered under subsection (c) of this
10 section is not in a condition that would enable another Program recipient to use it, the
11 [Department] AUTHORITY may give the equipment to any organization that will:

12 (1) Repair or attempt to repair the equipment; and

13 (2) Provide the equipment at no charge to other persons who require the
14 same equipment.

15 [15-130.] 15-1A-39.

16 (a) In this section, "seriously emotionally disturbed" means a condition that is:

17 (1) Manifest in an individual younger than 18 years or, if the individual
18 is in a residential treatment center, younger than 21 years;

19 (2) Diagnosed according to the current diagnostic classification system
20 that is recognized by the [Secretary] AUTHORITY; and

21 (3) Characterized by a functional impairment that substantially
22 interferes with or limits the child's role or functioning in the family, school, or
23 community activities.

24 (b) (1) The [Department] AUTHORITY shall apply to the [Health Care
25 Financing Administration] CENTERS FOR MEDICARE AND MEDICAID SERVICES of the
26 federal Department of Health and Human Services for a home- and
27 community-based services waiver under § 1915(c) of the federal Social Security Act in
28 order to receive federal matching funds for services to seriously emotionally disturbed
29 individuals who would otherwise require institutionalization in a residential
30 treatment center.

31 (2) The [Department] AUTHORITY shall apply to the [Health Care
32 Financing Administration] CENTERS FOR MEDICARE AND MEDICAID SERVICES of the
33 federal Department of Health and Human Services for a home- and
34 community-based services waiver under § 1915(c) of the federal Social Security Act in
35 order to receive federal matching funds for services to autistic children aged 1
36 through 21 years who would otherwise require institutionalization in an institution
37 for the developmentally disabled.

1 (c) In accordance with subsection (b)(1) and (2) of this section, the services to
2 be provided for seriously emotionally disturbed individuals or autistic children may
3 include, but are not limited to:

- 4 (1) Respite services;
- 5 (2) Family training and education;
- 6 (3) Day treatment services;
- 7 (4) Therapeutic integration services;
- 8 (5) Intensive individual support services;
- 9 (6) Therapeutic living services;
- 10 (7) Intensive in-home intervention services; and
- 11 (8) Specialized case management services.

12 (d) The State matching funds required to cover the Medicaid costs under the
13 waiver for autistic children shall be certified or otherwise provided by the Maryland
14 State Department of Education, local school systems, and local lead agencies.

15 (e) The State matching funds required to cover the Medicaid costs under the
16 waiver for seriously emotionally disturbed individuals shall be certified or otherwise
17 provided by the Maryland State Department of Education, local school systems, local
18 lead agencies, and the Mental Hygiene Administration.

19 (f) Subject to § 2-1246 of the State Government Article, the [Department]
20 AUTHORITY shall report to the General Assembly every 6 months concerning the
21 status of the [Department's] AUTHORITY'S applications under subsection (b) of this
22 section.

23 [15-131.] 15-1A-40.

24 (a) The [Department] AUTHORITY shall investigate development of
25 integrated care systems and the feasibility and desirability of applying for a home-
26 and community-based services waiver in order to maximize federal matching funds
27 for the provision of services to adults who:

- 28 (1) Have functional disabilities, including Alzheimer's disease and
29 related disorders;
- 30 (2) Have family income not greater than 200% of the federal poverty
31 level; and
- 32 (3) Would otherwise require nursing home institutionalization.

33 (b) The services covered under the waiver under this section may include:

- 1 (1) Routine and emergency respite care;
- 2 (2) Adult day care;
- 3 (3) Personal care;
- 4 (4) Case management; and
- 5 (5) Homemaker services.

6 (c) The [Department] AUTHORITY may place a reasonable limit on the
7 number of individuals or on the geographic area of the State included in the waiver
8 under this section.

9 [15-132.] 15-1A-41.

- 10 (a) (1) In this section the following terms have the meanings indicated.
- 11 (2) "Assisted living program" has the meaning stated in § 19-1801 of this
12 article.
- 13 (3) "Assisted living services" means services provided by an assisted
14 living program as defined in regulations adopted by the [Department] AUTHORITY.
- 15 (4) "Case management services" means services that assist waiver
16 eligible individuals in gaining access to needed waiver services and other needed
17 medical, social, housing, and other supportive services.
- 18 (5) "Environmental modifications" has the meaning stated in regulations
19 adopted by the [Department] AUTHORITY and includes those physical adaptations to
20 the home or residence which are necessary to ensure the health, welfare, and safety of
21 the individual or which enable the individual to function with greater independence
22 and without which, the individual would require admission to or continued stay in a
23 nursing facility.
- 24 (6) "Health related care and services", for purposes of paragraph (8) of
25 this subsection, includes:
 - 26 (i) 24-hour supervision and observation by a licensed care
27 provider;
 - 28 (ii) Medication administration;
 - 29 (iii) Inhalation therapy;
 - 30 (iv) Bladder and catheter management;
 - 31 (v) Assistance with suctioning; and
 - 32 (vi) Assistance with treatment of skin disorders and dressings.

1 (7) "Home health care services" means those services defined in § 19-401
2 of this article and in 42 C.F.R. 440.70.

3 (8) "Intermediate level of care", for purposes of paragraph (10)(ii) of this
4 subsection, includes health related care and services provided to individuals who do
5 not require hospital or a skilled level of nursing facility care but whose mental,
6 physical, functional, or cognitive condition requires health services that:

7 (i) Are above the level of room and board;

8 (ii) Are provided on a regular basis; and

9 (iii) Can be made available to the individuals through institutional
10 facilities.

11 (9) "Medically and functionally impaired" means an individual who is
12 assessed by the [Department] AUTHORITY to require services provided by a nursing
13 facility as defined in this section, and who, but for the receipt of these services, would
14 require admission to a nursing facility within 30 days.

15 (10) (i) "Nursing facility" means a facility that provides skilled nursing
16 care and related services, rehabilitation services, and health related care and services
17 above the level of room and board needed on a regular basis in accordance with § 1919
18 of the federal Social Security Act.

19 (ii) "Nursing facility" includes a facility that provides services to
20 individuals certified as requiring an intermediate level of care.

21 (11) "Personal care services" means those services as defined in
22 accordance with 42 C.F.R. 440.167 and in regulations adopted by the [Department]
23 AUTHORITY.

24 (12) "Respite care services" has the meaning stated in regulations adopted
25 by the [Department] AUTHORITY and includes those services provided to individuals
26 unable to care for themselves furnished on a short-term basis because of the absence
27 or need for relief of those persons normally providing the care.

28 (13) "Waiver" means a home and community based services waiver under
29 § 1915(c) of the federal Social Security Act, submitted by the [Department]
30 AUTHORITY to the [Health Care Financing Administration] CENTERS FOR
31 MEDICARE AND MEDICAID SERVICES, as required by subsections (b) and (c) of this
32 section.

33 (14) "Waiver services" means the services covered under an approved
34 waiver that:

35 (i) Are needed and chosen by an eligible waiver participant as an
36 alternative to admission to or continued stay in a nursing facility;

37 (ii) Are part of a plan of care approved by the program;

1 (iii) Assure the waiver participant's health and safety in the
2 community; and

3 (iv) Cost no more per capita to receive services in the community
4 than in a nursing facility.

5 (b) On or before August 1, 1999, the [Department] AUTHORITY shall apply to
6 the [Health Care Financing Administration] CENTERS FOR MEDICARE AND
7 MEDICAID SERVICES of the United States Department of Health and Human Services
8 for an amendment to the existing home and community based services waiver
9 (Control Number 0265.90) under § 1915(c) of the federal Social Security Act to receive
10 federal matching funds for waiver services received by eligible medically and
11 functionally impaired individuals participating in the waiver.

12 (c) The [Department's] AUTHORITY'S waiver application shall include the
13 following:

14 (1) An initial cap on waiver participation at 7,500 individuals;

15 (2) A limit on annual waiver participation based on State General Fund
16 support as provided in the budget bill;

17 (3) Elimination of the current requirements that waiver applicants be at
18 least 62 years old and be eligible for or already receive a subsidy for the senior
19 assisted housing program;

20 (4) Financial eligibility criteria which include:

21 (i) The current federal and State medical assistance long-term
22 care rules for using services provided by a nursing facility, per §§ 1902, 1919, and
23 1924 of the federal Social Security Act, and applicable regulations adopted by the
24 [Department] AUTHORITY;

25 (ii) Medically needy individuals using services provided by a
26 nursing facility under the current federal and State medical assistance eligibility
27 criteria governed by regulations adopted by the Department and § 1919 of the federal
28 Social Security Act;

29 (iii) Categorically needy individuals with income up to 300% of the
30 applicable payment rate for supplemental security income; and

31 (5) Waiver services that include at least the following:

32 (i) Assisted living services;

33 (ii) Case management services;

34 (iii) Personal care services and homemaker services;

35 (iv) Home health care services;

- 1 (v) Respite care services;
- 2 (vi) Assistive technology;
- 3 (vii) Environmental modifications;
- 4 (viii) Medically necessary over-the-counter supplies ordered by a
5 physician and not otherwise covered by the program;
- 6 (ix) Environmental assessments;
- 7 (x) Family/consumer training;
- 8 (xi) Personal emergency response systems;
- 9 (xii) Home delivered meals and dietitian/nutrition services; and
- 10 (xiii) Ambulance or other transportation services for individuals
11 receiving assisted living services or home health care services for being transported to
12 and from health care providers and facilities for medical diagnosis or medically
13 necessary treatment or care.

14 (d) The [Department] AUTHORITY shall work with the [Maryland Health
15 Resource Planning Commission] MARYLAND HEALTH CARE COMMISSION to try to
16 assure that 20% of assisted living program waiver beds are nursing facility beds that
17 have been converted to assisted living beds.

18 (e) This section may not be construed to affect, interfere with, or interrupt any
19 services reimbursed through the Maryland Medical Assistance State Program under
20 this title.

21 (f) If a person determined to be eligible to receive waiver services under this
22 section desires to receive waiver services and an appropriate placement is available,
23 the [Department] AUTHORITY shall authorize the placement.

24 (g) Waiver services shall be jointly administered by the [Departments]
25 DEPARTMENT of Aging, DEPARTMENT OF Human Resources, and [Health and Mental
26 Hygiene] THE AUTHORITY.

27 (h) The [Department] AUTHORITY, in consultation with representatives of
28 the affected industry and advocates for waiver candidates, and with the approval of
29 the Department of Aging and the Department of Human Resources, shall adopt
30 regulations to implement this section within 180 days of receipt of approval of the
31 amended waiver application from the [Health Care Financing Administration]
32 CENTERS FOR MEDICARE AND MEDICAID SERVICES of the United States Department
33 of Health and Human Services.

34 (i) Subject to § 2-1246 of the State Government Article, the [Department]
35 AUTHORITY shall report to the General Assembly every 6 months concerning the

1 status of the [Department's] AUTHORITY'S application under subsections (b) and (c)
2 of this section.

3 [15-133.] 15-1A-42.

4 (a) The State shall apply to the [Health Care Financing Administration]
5 CENTERS FOR MEDICARE AND MEDICAID SERVICES of the United States Department
6 of Health and Human Services for grants to assist states in improving home and
7 community-based service systems, including:

8 (1) Real choice system change grants;

9 (2) Nursing facility transition grants and "access housing" grants; and

10 (3) Community-based attendant services with consumer control grants.

11 (b) The [Department] AUTHORITY shall seek input from eligible individuals,
12 the individuals' representatives, and service providers in developing and
13 implementing the Program.

14 (c) On or before July 1, 2001, the [Department] AUTHORITY shall notify the
15 [Health Care Financing Administration] CENTERS FOR MEDICARE AND MEDICAID
16 SERVICES of the United States Department of Health and Human Services of
17 Maryland's intent to expand the current Medicaid home- and community-based
18 waiver for adults with physical disabilities, under § 1915(c) of the federal Social
19 Security Act to redirect funds to develop appropriate funding for this Program.

20 (d) Subject to § 2-1246 of the State Government Article, the [Department]
21 AUTHORITY shall report to the General Assembly every 3 months concerning the
22 status of the [Department's] AUTHORITY'S applications under subsections (a) and (c)
23 of this section, including the number of individuals budgeted for the Medicaid home-
24 and community-services based waiver for adults with physical disabilities.

25 [15-134.] 15-1A-43.

26 (a) If the [Department] AUTHORITY applies for a Medical Assistance Program
27 waiver or modifies or amends an existing Medical Assistance Program waiver, the
28 [Department] AUTHORITY shall give notice of the application by publication in the
29 Maryland Register.

30 (b) For 30 days following publication of any notice published under subsection
31 (a) of this section, the [Department] AUTHORITY shall:

32 (1) Make the Medical Assistance Program waiver application available
33 to the public during business hours; and

34 (2) Provide an opportunity to receive public comments on the Medical
35 Assistance Program waiver application.

1 15-201.

2 (a) In this subtitle the following words have the meanings indicated.

3 (b) "Applicant" means an individual who applies for assistance from the
4 Program.

5 (c) (1) Except as provided in paragraph (2) of this subsection, "family"
6 means:

7 (i) The applicant or recipient;

8 (ii) The applicant's or recipient's spouse if the spouse lives with the
9 applicant or recipient; and

10 (iii) The applicant's or recipient's children under the age of 18 years
11 if the children live with the applicant or recipient.

12 (2) If the applicant is a child under the age of 18 years, "family" means:

13 (i) The minor applicant's or recipient's parents; and

14 (ii) At the option of the minor applicant's or recipient's parents, the
15 minor applicant's or recipient's siblings.

16 (d) "Program" means the Maryland AIDS Insurance Assistance Program.

17 (e) "Recipient" means an individual receiving assistance from the Program.

18 15-202.

19 (a) The [Department of Health and Mental Hygiene] AUTHORITY shall
20 administer a Maryland AIDS Insurance Assistance Program for HIV positive
21 individuals.

22 (b) There shall be no more than 450 recipients enrolled in the Program at any
23 one time.

24 (c) Except as provided in subsection (d) of this section, an individual is eligible
25 for the Program if:

26 (1) Cash assets owned by the individual's family, including savings
27 accounts, checking accounts, and stocks and bonds, do not exceed \$10,000;

28 (2) The individual's family income, earned and unearned, does not
29 exceed [300 percent] 300% of the federal poverty level;

30 (3) (i) The individual is eligible for and has applied for continuation of
31 benefits under one of the following authorities:

- 1 1. The Consolidated Omnibus Budget Reconciliation Act of
2 1985, P.L. 99-272, and any subsequent modifications to that Act;
- 3 2. The Federal Employees Health Benefits Amendment Act
4 of 1988, P.L. 100-654, and any subsequent modifications to that Act; or
- 5 3. The Insurance Article; or
- 6 (ii) The individual is receiving health benefits:
 - 7 1. Under a policy issued by an authorized insurer or
8 nonprofit health service plan;
 - 9 2. As an enrollee of an authorized health maintenance
10 organization; or
 - 11 3. From an employer under a health benefits plan that meets
12 the conditions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §
13 1001 et seq., and any subsequent modifications to that Act;
- 14 (4) The individual is not eligible for health insurance through another
15 family member;
- 16 (5) A physician certifies that the individual is:
 - 17 (i) HIV positive; and
 - 18 (ii) Due to this illness, [the individual is] either too ill to continue
19 working in the individual's current position, or there is a substantial likelihood that
20 within 3 months the individual will be unable to work;
- 21 (6) The individual is a resident of the State; and
- 22 (7) The [Department] AUTHORITY determines that it is cost effective to
23 enroll the individual in the Program.
- 24 (d) Notwithstanding the provisions of subsection (c)(1) and (2) of this section,
25 an individual is eligible for the Program if:
 - 26 (1) Cash assets owned by the individual's family, including savings
27 accounts, checking accounts, stocks, and bonds, that exceed \$10,000 are paid to the
28 [Department] AUTHORITY to be used for the payment of health insurance on behalf
29 of the individual;
 - 30 (2) The individual's family income, earned and unearned, that exceeds
31 [300 percent] 300% of the federal poverty level is paid to the [Department]
32 AUTHORITY to be used for the payment of health insurance on behalf of the
33 individual; and
 - 34 (3) The individual meets the eligibility requirements of subsection (c)(3),
35 (4), (5), (6), and (7) of this section.

1 15-203.

2 (a) The [Department] AUTHORITY shall adopt regulations for the payment of
3 health insurance premiums to insurance carriers or employers under the Program.

4 (b) The Program shall comply with the applicable provisions of all federal and
5 State laws that relate to the continuation of health benefits.

6 (c) If a recipient is a Medicare beneficiary, the Program may pay premiums
7 only for supplemental Medicare coverage unless the [Department] AUTHORITY finds
8 that it is more cost-effective for the Program to pay premiums for other health
9 insurance coverage available to the recipient.

10 15-204.

11 The [Department] AUTHORITY shall adopt regulations that authorize the
12 denial, restriction, or termination of benefits for recipients who commit acts of abuse
13 or fraud against the Program.

14 15-205.

15 (a) The [Department] AUTHORITY shall, subject to § 2-1246 of the State
16 Government Article, provide the Governor and the General Assembly with an annual
17 report summarizing the Program expenditures, numbers of recipients, Program
18 effectiveness, the estimated savings to the Medical Assistance Program, additional
19 costs incurred by private insurance companies, and the loss of federal funding.

20 (b) The [Department] AUTHORITY may periodically survey recipients to
21 gather information for the annual report.

22 15-301.

23 (a) There is a Maryland Children's Health Program ADMINISTERED BY THE
24 AUTHORITY.

25 (b) The Maryland Children's Health Program shall provide, subject to the
26 limitations of the State budget and any other requirements imposed by the State and
27 as permitted by federal law or waiver, comprehensive medical care and other health
28 care services to an individual who has a family income at or below 300 percent of the
29 federal poverty guidelines and who is under the age of 19 years.

30 (c) The Maryland Children's Health Program shall be administered:

31 (1) For individuals whose family income is at or below 200 percent of the
32 federal poverty guidelines, through the program under Subtitle 1 of this title
33 [requiring individuals to enroll in managed care organizations]; or

34 (2) For eligible individuals whose family income is above 200 percent,
35 but at or below 300 percent of the federal poverty guidelines, through the MCHP
36 private option plan under § 15-301.1 of this subtitle.

1 [(d) (1) The Department shall provide eligible individuals and health care
2 providers with an accurate directory or other listing of all available providers:

3 (i) In written form, made available upon request; and

4 (ii) On an Internet database.

5 (2) The Department shall update the Internet database at least every 30
6 days.

7 (3) The written directory shall include a conspicuous reference to the
8 Internet database.]

9 15-301.1.

10 (a) (1) In this section the following words have the meanings indicated.

11 (2) "Carrier" means:

12 (i) An insurer;

13 (ii) A nonprofit service plan;

14 (iii) A health maintenance organization; or

15 (iv) Any other person that provides health benefit plans subject to
16 regulation by the State.

17 (3) "Eligible individual" means an individual who qualifies to participate
18 in the Maryland Children's Health Program under § 15-301(b) of this subtitle and
19 whose family income is above 200 percent, but at or below 300 percent of the federal
20 poverty guidelines.

21 (4) "Family contribution" means the portion of the premium cost paid for
22 an eligible individual to enroll and participate in the Maryland Children's Health
23 Program.

24 (5) "MCHP private option plan" means the plan established under this
25 section to provide access to health insurance coverage to eligible individuals through
26 employer-sponsored health benefit plans and managed care organizations under the
27 Maryland Children's Health Program.

28 (b) This section applies only to individuals whose family income is above 200
29 percent, but at or below 300 percent of the federal poverty guidelines.

30 (c) (1) An eligible individual who is enrolled in the MCHP private option
31 plan shall be insured through an employer's health benefit plan if:

32 (i) The employer offers family health insurance coverage to the
33 parent or guardian of an eligible individual;

1 (ii) The employer elects to participate in the MCHP private option
2 plan;

3 (iii) The parent or guardian of an eligible individual is insured
4 under the employer-sponsored health benefit plan;

5 (iv) The employer contributes to family health insurance coverage
6 at a rate no less than 30 percent of annual premiums;

7 (v) The plan includes a benefit package that is determined by the
8 [Department] AUTHORITY to be at least equivalent to the Comprehensive Standard
9 Health Benefit Plan established under § 15-1207 of the Insurance Article; and

10 (vi) The plan does not impose cost sharing requirements on eligible
11 individuals.

12 (2) [(i) The State's cost for coverage of an eligible individual enrolled in
13 the MCHP private option plan may not be greater than the cost of coverage if the
14 eligible individual was insured through a managed care organization as defined in §
15 15-101(f) of this title.

16 [(ii)] If an employer-sponsored health benefit plan that meets the
17 criteria under paragraph (1) of this subsection is not available to the eligible
18 individual [or if the Department determines that the employer-sponsored health
19 benefit plan is not cost effective as required in item (i) of this paragraph], the eligible
20 individual shall be insured [through a managed care organization as defined in §
21 15-101(f) of this title] AS PROVIDED UNDER SUBTITLE 1A OF THIS TITLE.

22 (d) The [Department] AUTHORITY shall facilitate coverage of eligible
23 individuals under an employer-sponsored health benefit plan by:

24 (1) Evaluating employer-sponsored health benefit plans to determine
25 whether specific plans meet applicable State and federal requirements;

26 (2) Assisting employers that wish to participate in the MCHP private
27 option plan to meet the eligibility criteria established under subsection (c) of this
28 section;

29 (3) Collecting the family contribution under subsection (e) of this section;

30 (4) Forwarding the family contribution and the State's portion of the
31 premium directly to the carrier; and

32 (5) Assisting employers in enrolling the eligible dependents of employees
33 in the employer-sponsored health benefit plan.

34 (e) (1) As a requirement of enrollment and participation in the MCHP
35 private option plan, through either an employer-sponsored health benefit plan or a
36 managed care organization, the parent or guardian of an eligible individual shall
37 agree to pay the following annual family contribution:

1 (i) For an eligible individual whose family income is above 200
2 percent, but at or below 250 percent of the federal poverty guidelines, an amount
3 equal to 2 percent of the annual income of a family of two at 200 percent of the federal
4 poverty guidelines; and

5 (ii) For an eligible individual whose family income is above 250
6 percent, but at or below 300 percent of the federal poverty guidelines, an amount
7 equal to 2 percent of the annual income of a family of two at 250 percent of the federal
8 poverty guidelines.

9 (2) The family contribution amounts required under paragraph (1) of
10 this subsection apply on a per family basis regardless of the number of eligible
11 individuals each family has enrolled in the MCHP private option plan.

12 (f) The [Department] AUTHORITY shall adopt regulations necessary to
13 implement this section.

14 15-302.

15 (a) (1) The [Department] AUTHORITY shall monitor applications to
16 determine whether employers and employees have voluntarily terminated coverage
17 under an employer sponsored health benefit plan that included dependent coverage in
18 order to participate in the Maryland Children's Health Program established under §§
19 15-301 and 15-301.1 of this subtitle.

20 (2) The [Department] AUTHORITY, in particular, shall review
21 applications of individuals who qualified for Program benefits under the Maryland
22 Children's Health Program established under §§ 15-301 and 15-301.1 of this subtitle.

23 (b) (1) An application may be disapproved if it is determined that an
24 individual under the age of 19 years to be covered under the Maryland Children's
25 Health Program, for whom the application was submitted, was covered by an
26 employer sponsored health benefit plan with dependent coverage which was
27 voluntarily terminated within 6 months preceding the date of the application.

28 (2) In determining whether an applicant has voluntarily terminated
29 coverage under an employer sponsored health benefit plan for purposes of paragraph
30 (1) of this subsection, a voluntary termination may not be construed to include:

31 (i) Loss of employment due to factors other than voluntary
32 termination;

33 (ii) Change to a new employer that does not provide an option for
34 dependent coverage;

35 (iii) Change of address so that no employer sponsored health benefit
36 plan is available;

37 (iv) Discontinuation of health benefits to all dependents of
38 employees of the applicant's employer; or

1 (v) Expiration of the applicant's continuation of coverage under the
2 Consolidated Omnibus Budget Reconciliation Act (COBRA).

3 [15-304.] 15-303.

4 (a) (1) For purposes of increasing the number of eligible individuals who
5 enroll in the Maryland Children's Health Program established under §§ 15-301 and
6 15-301.1 of this subtitle, the [Department] AUTHORITY shall develop and implement
7 a school-based outreach program.

8 (2) As appropriate to carry out its responsibilities under paragraph (1) of
9 this subsection, the [Department] AUTHORITY may enter into contracts with county
10 boards of education to provide information at public schools on the Maryland
11 Children's Health Program established under §§ 15-301 and 15-301.1 of this subtitle.

12 (b) (1) For purposes of this subsection, "community-based organization"
13 includes day care centers, schools, and school-based health clinics.

14 (2) In addition to the school-based outreach program established under
15 subsection (a) of this section, the [Department] AUTHORITY, in consultation with the
16 Maryland Medicaid Advisory Committee [established under § 15-103(b) of this title],
17 shall develop mechanisms for outreach for the program with a special emphasis on
18 identifying children who may be eligible for program benefits under the Maryland
19 Children's Health Program established under §§ 15-301 and 15-301.1 of this subtitle.

20 (3) From the mechanisms to be developed for outreach under paragraph
21 (2) of this subsection, one mechanism shall include the development and
22 dissemination of mail-in applications and appropriate outreach materials through
23 community-based organizations, community-based providers, the Office of the State
24 Comptroller, the [Departments] DEPARTMENT of Human Resources [and Health and
25 Mental Hygiene], THE AUTHORITY, county boards of education, and any other
26 appropriate State agency or unit the [Department] AUTHORITY considers
27 appropriate.

28 [15-305.] 15-304.

29 The purpose of the Health Care Foundation under this section is to:

30 (1) Develop programs to expand the availability of health insurance
31 coverage to low-income, uninsured children;

32 (2) Involve the private health insurance market in the delivery of health
33 insurance coverage to low-income, uninsured children in the State and their families;

34 (3) Identify and aggressively pursue a mix of State, federal, and private
35 funds, including grants, to enable the Foundation to provide and fund health care
36 insurance coverage;

1 (4) Develop methods to minimize the effect of employers or employees
2 terminating employer sponsored health insurance or privately purchased health care
3 insurance; and

4 (5) Coordinate its activities with the other necessary entities in order to
5 address the health care needs of the low-income, uninsured children of the State and
6 their families.

7 15-501.

8 (a) An individual who is eligible for medical assistance at the time of
9 application for admission to a licensed nursing home or would become eligible within
10 6 months following admission shall be provided a comprehensive face-to-face
11 evaluation prior to admission, at no charge to the individual. The [Department]
12 AUTHORITY, under the Maryland Medical Assistance Program, shall pay for the
13 evaluation. The evaluation shall include an assessment of an individual's health,
14 social and functional status and recommendations for available services which could
15 appropriately substitute for nursing home care. The evaluation is advisory only and
16 may not serve as the basis for any action, including denial or commencement of
17 benefits, that restricts the freedom of any individual to select from among any of the
18 available services, including nursing home care, for which the individual is found to
19 be medically eligible. Prior to beginning the evaluation process and annually
20 thereafter, the [Department] AUTHORITY shall prepare and publish an inventory of
21 available services for use in the evaluation and shall provide this information for
22 assistance to the individual upon completion of the evaluation.

23 (b) The [Department] AUTHORITY shall adopt rules and regulations to carry
24 out the provisions of this section.

25 (c) This section may not be construed to require a hospital or physician to
26 detain a patient for an evaluation beyond the appropriate date of discharge.

27 SECTION 3. AND BE IT FURTHER ENACTED, That:

28 (a) On or before October 1, 2003, the Department of Health and Mental
29 Hygiene shall submit to the Centers for Medicare and Medicaid Services an
30 application for a waiver to transfer oversight of the medical assistance programs
31 under Section 2 of this Act from the Department of Health and Mental Hygiene to the
32 Maryland Medical Assistance Authority.

33 (b) The Department shall include in its application under subsection (a) of this
34 section provisions for the establishment of the Maryland Medical Assistance Program
35 to be administered by the Maryland Medical Assistance Authority, that, at a
36 minimum:

37 (1) ensure continuity of coverage for Program recipients upon transition
38 of oversight of the Maryland Medical Assistance Program;

39 (2) ensure a maintenance of benefits for children that are enrolled in the
40 Maryland Medical Assistance Program or the Children's Health Program; and

1 (3) provide for the provision of benefits under the Maryland Medical
2 Assistance Program and Children's Health Program on a fee-for-service basis.

3 (c) The Secretary of Health and Mental Hygiene shall monitor the status of
4 the waiver application and shall promptly notify the Department of Legislative
5 Services when the waiver application has been approved or denied.

6 SECTION 4. AND BE IT FURTHER ENACTED, That all the functions, powers,
7 duties, equipment, assets, liabilities, and employees of the medical assistance
8 programs of the Department of Health and Mental Hygiene shall be transferred to the
9 Maryland Medical Assistance Authority.

10 SECTION 5. AND BE IT FURTHER ENACTED, That the Maryland Medical
11 Assistance Authority shall report to the Senate Finance Committee and the House
12 Health and Government Operations Committee on the Authority's effectiveness in
13 providing comprehensive health care to those citizens eligible to receive medical
14 assistance. The Authority shall submit the report to the Committees no later than 1
15 year after this Act takes effect. The report shall include information about the effect
16 of the transfer of authority over medical assistance programs from the Department of
17 Health and Mental Hygiene to the Maryland Medical Assistance Authority on the
18 continuity of care for recipients of medical assistance, a comprehensive financial
19 assessment of the Authority, the efforts of the Authority in seeking options for
20 employer buy-ins into the Program, and the availability and effectiveness of the
21 Authority in establishing preventative programs.

22 SECTION 6. AND BE IT FURTHER ENACTED, That the publisher of the
23 Annotated Code of Maryland, in consultation with and subject to the approval of the
24 Department of Legislative Services, shall correct, with no further action required by
25 the General Assembly, cross-references and terminology rendered incorrect by this
26 Act or by any other Act of the General Assembly of 2003 that affects provisions
27 enacted by this Act. The publisher shall adequately describe any such corrections in
28 editor's notes following the sections of the Code affected.

29 SECTION 7. AND BE IT FURTHER ENACTED, That the terms of the initial
30 members of the Maryland Medical Assistance Authority shall expire as follows:

31 (1) 3 members in 2005;

32 (2) 2 members in 2006; and

33 (3) 2 members in 2007.

34 SECTION 8. AND BE IT FURTHER ENACTED, That Sections 1, 2, 4, 5, 6, and
35 7 of this Act shall take effect on the date that the federal Centers for Medicare and
36 Medicaid Services approves a waiver applied for in accordance with Section 3 of this
37 Act. If the waiver is denied, Sections 1, 2, 4, 5, 6, and 7 of this Act shall be null and
38 void without the necessity of further action by the General Assembly.

39 SECTION 9. AND BE IT FURTHER ENACTED, That, subject to the provisions
40 of Section 8 of this Act, this Act shall take effect July 1, 2003.

