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By: **Delegates Nathan-Pulliam, Benson, Bohanan, Feldman, Hammen, Murray, and V. Turner**
Introduced and read first time: February 10, 2005
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Medicaid Quality Improvement Act of 2005

FOR the purpose of authorizing the Secretary of Health and Mental Hygiene, in consultation with the Insurance Commissioner, to adjust capitation payments for a managed care organization based on a certain loss ratio of the managed care organization; establishing certain procedures, standards, and limits for the adjustment of capitation payments; authorizing the Secretary, in consultation with the Commissioner, to adjust capitation payments based on a certain quality performance initiative adopted by the Secretary; establishing certain standards and procedures relating to the quality performance initiative; requiring the Secretary to adopt certain regulations on or before a certain date; providing that this Act may not be implemented until the Secretary adopts certain regulations; and generally relating to adjustments to capitation payments to managed care organizations and quality of care.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-605(c)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY adding to
Article - Insurance
Section 15-605.1
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

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

Article - Insurance

15-605.

(c) (1) For a health benefit plan that is issued under Subtitle 12 of this title, the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 75%.

(2) (i) Subject to subparagraph (ii) of this paragraph, for a health benefit plan that is issued to individuals the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 60%.

(ii) Subparagraph (i) of this paragraph does not apply to an insurance product that:

1. is listed under § 15-1201(f)(3) of this title; or

2. is nonrenewable and has a policy term of no more than 6 months.

(iii) The Commissioner may establish a loss ratio for each insurance product described in subparagraph (ii)1 and 2 of this paragraph.

(3) The authority of the Commissioner under paragraphs (1) and (2) of this subsection to require an insurer, nonprofit health service plan, or health maintenance organization to file new rates based on loss ratio:

(i) is in addition to any other authority of the Commissioner under this article to require that rates not be excessive, inadequate, or unfairly discriminatory; and

(ii) does not limit any existing authority of the Commissioner to determine whether a rate is excessive.

(4) (i) In determining whether to require an insurer to file new rates under this subsection, the Commissioner may consider the amount of health insurance premiums earned in the State on individual policies in proportion to the total health insurance premiums earned in the State for the insurer.

(ii) The insurer shall provide to the Commissioner the information necessary to determine the proportion of individual health insurance premiums to total health insurance premiums as provided under this paragraph.

(5) [The] IN ACCORDANCE WITH § 15-605.1 OF THIS SUBTITLE, THE Secretary of Health and Mental Hygiene, in consultation with the Commissioner and in accordance with their memorandum of understanding, may adjust capitation payments for a managed care organization or for the Maryland Medical Assistance Program of a managed care organization that is a certified health maintenance organization:

(i) if the loss ratio is less than 80% during calendar year 1997; and

(ii) during each subsequent calendar year if the loss ratio is less than 85%.

(6) [A loss ratio reported under paragraph (5) of this subsection shall be calculated separately and may not be part of another loss ratio reported under this section.

(7)] Any rebate received by a managed care organization may not be considered part of the loss ratio of the managed care organization.

15-605.1.

(A) THE SECRETARY OF HEALTH AND MENTAL HYGIENE, IN CONSULTATION WITH THE COMMISSIONER AND IN ACCORDANCE WITH THEIR MEMORANDUM OF UNDERSTANDING, MAY ADJUST CAPITATION PAYMENTS FOR A MANAGED CARE ORGANIZATION IF THE LOSS RATIO OF THE MANAGED CARE ORGANIZATION IS LESS THAN 85%.

(B) (1) THE SECRETARY SHALL CALCULATE THE MEDICAL LOSS RATIO THAT SERVES AS THE BASIS FOR A CAPITATION ADJUSTMENT:

(I) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, BASED ON THE AUDITED HEALTHCHOICE FINANCIAL MONITORING REPORT FILED BY THE MANAGED CARE ORGANIZATION;

(II) IN A MANNER THAT INCLUDES THE MEDICAL ADMINISTRATION EXPENSES OF A MANAGED CARE ORGANIZATION AS AN ELEMENT OF MEDICAL EXPENSES IN THE LOSS RATIO; AND

(III) ON A 3-YEAR AVERAGE LOSS RATIO BASED ON THE MEDICAL LOSS RATIOS OF THE PRECEDING 3 CALENDAR YEARS.

(2) IF A MANAGED CARE ORGANIZATION DOES NOT REPORT MEDICAL ADMINISTRATION EXPENSES ON A HEALTHCHOICE FINANCIAL MONITORING REPORT, THE MANAGED CARE ORGANIZATION SHALL REPORT ALL MEDICAL ADMINISTRATION EXPENSES TO THE SECRETARY ON THE FORM REQUIRED BY THE SECRETARY.

(C) PRIOR TO IMPOSING AN ADJUSTMENT TO THE CAPITATION PAYMENT TO A MANAGED CARE ORGANIZATION UNDER THIS SECTION, THE SECRETARY SHALL:

(1) CONSULT WITH THE COMMISSIONER;

(2) SUBMIT TO THE COMMISSIONER THE CALCULATION OF THE MEDICAL LOSS RATIO THAT IS THE BASIS FOR THE ADJUSTMENT IN ORDER FOR THE COMMISSIONER TO VERIFY THE CALCULATION; AND

(3) OBTAIN FROM THE COMMISSIONER A DETERMINATION THAT THE IMPOSITION OF AN ADJUSTMENT WOULD NOT IMPAIR THE FINANCIAL CONDITION OF THE MANAGED CARE ORGANIZATION.

(D) A CAPITATION ADJUSTMENT UNDER THIS SECTION MAY NOT EXCEED:

(1) IN THE FIRST YEAR IN WHICH AN ADJUSTMENT IS MADE, THE LESSER OF:

(I) 50% OF THE DIFFERENCE BETWEEN THE CAPITATION PAID TO THE MANAGED CARE ORGANIZATION AND THE CAPITATION THAT WOULD HAVE RESULTED IN AN 80% MEDICAL LOSS RATIO; OR

(II) 25% OF THE NET INCOME OF THE MANAGED CARE ORGANIZATION FOR THE YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS CALCULATED;

(2) IN THE SECOND YEAR IN WHICH AN ADJUSTMENT IS MADE, THE LESSER OF:

(I) 75% OF THE DIFFERENCE BETWEEN THE CAPITATION PAID TO THE MANAGED CARE ORGANIZATION AND THE CAPITATION THAT WOULD HAVE RESULTED IN AN 80% MEDICAL LOSS RATIO; OR

(II) 35% OF THE NET INCOME OF THE MANAGED CARE ORGANIZATION FOR THE YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS CALCULATED; AND

(3) IN ANY SUBSEQUENT YEAR IN WHICH AN ADJUSTMENT IS MADE, 50% OF THE AVERAGE NET INCOME OF THE MANAGED CARE ORGANIZATION FOR THE YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS CALCULATED.

(E) IN EXERCISING DISCRETION TO MAKE A CAPITATION ADJUSTMENT UNDER THIS SECTION, THE SECRETARY MAY NOT MAKE AN ADJUSTMENT UNLESS THE SECRETARY DETERMINES THAT THE OBJECTIVES OF THE HEALTHCHOICE PROGRAM WOULD BE ADVANCED BY THE ADJUSTMENT.

(F) A CAPITATION ADJUSTMENT UNDER THIS SECTION MAY NOT BE MADE IF, FOR THE CALENDAR YEAR FOR WHICH AN ADJUSTMENT IS CONSIDERED:

(1) THE 3-YEAR AVERAGE MEDICAL LOSS RATIO OF THE MANAGED CARE ORGANIZATION IS LESS THAN 85%, BUT EQUAL TO OR GREATER THAN 80%; AND

(2) (I) THE SERVICE COUNT RATIO, WHICH IS THE NUMBER OF SERVICES COMPARED TO THE AVERAGE YEARLY ENROLLMENT, FOR THE MANAGED CARE ORGANIZATION IS AT OR ABOVE THE AVERAGE MANAGED CARE ORGANIZATION SERVICE COUNT RATIO FOR ALL MANAGED CARE ORGANIZATIONS AS DETERMINED BY THE SECRETARY; OR

(II) THE MANAGED CARE ORGANIZATION ACHIEVED:

1. "ACCEPTABLE" SCORES FOR ALL ELEMENTS OF THE SECRETARY'S QUALITY PERFORMANCE INITIATIVE; OR

2. AT LEAST AS MANY "INCENTIVE" SCORES AS "DISINCENTIVE" SCORES.

(G) (1) A MANAGED CARE ORGANIZATION THAT IS SUBJECT TO AN ADJUSTMENT UNDER THIS SECTION:

(I) SHALL RECEIVE NOTICE THAT AN ADJUSTMENT IS BEING CONSIDERED AND THE GROUNDS FOR THE ADJUSTMENT; AND

(II) IS ENTITLED TO A HEARING UNDER THE TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE.

(2) THE FILING OF A REQUEST FOR A HEARING SHALL STAY THE IMPLEMENTATION OF THE ADJUSTMENT.

(H) (1) AS PART OF A QUALITY PERFORMANCE INITIATIVE AND IN ORDER TO ENSURE THE DELIVERY OF QUALITY HEALTH CARE BY MANAGED CARE ORGANIZATIONS, THE SECRETARY, IN CONSULTATION WITH THE COMMISSIONER AND IN ACCORDANCE WITH THEIR MEMORANDUM OF UNDERSTANDING, MAY ADJUST CAPITATION PAYMENTS FOR A MANAGED CARE ORGANIZATION.

(2) THE QUALITY PERFORMANCE INITIATIVE UNDER THIS SUBSECTION SHALL:

(I) BE BASED ON A CORE SET OF PERFORMANCE STANDARDS AND QUALITY MEASURES THAT:

1. ARE RELEVANT TO AND IN PROPORTION TO THE POPULATIONS SERVED BY THE MANAGED CARE ORGANIZATIONS;

2. ACCOMMODATE DIFFERENCES AMONG MANAGED CARE ORGANIZATIONS IN TERMS OF STRUCTURE, HEALTH CARE DELIVERY SYSTEM, AND POPULATION SERVED;

3. ARE DEVELOPED IN CONSULTATION WITH EXPERTS IN THE FIELD OF HEALTH CARE QUALITY FOR THOSE POPULATIONS SERVED BY MANAGED CARE ORGANIZATIONS;

4. ARE BASED ON ABSOLUTE RATHER THAN RELATIVE PERFORMANCE BY MANAGED CARE ORGANIZATIONS; AND

5. ARE GROUPED INTO THE FOLLOWING CATEGORIES OF PERFORMANCE:

A. "ACCEPTABLE";

B. "INCENTIVE"; AND

C. "DISINCENTIVE";

(II) PROVIDE FOR A SYSTEM OF FINANCIAL INCENTIVES AND DISINCENTIVES LINKED TO THE SCORES OF THE MANAGED CARE ORGANIZATIONS ON EACH OF THE QUALITY MEASURES AND PERFORMANCE STANDARDS;

(III) SERVE AS THE SINGLE, COMPREHENSIVE QUALITY MEASUREMENT AND IMPROVEMENT INITIATIVE OF THE SECRETARY; AND

(IV) BE ADOPTED BY REGULATION.

SECTION 2. AND BE IT FURTHER ENACTED, That the requirements of this Act may not be implemented until the Secretary of Health and Mental Hygiene adopts regulations as required by this Act. The Secretary shall adopt regulations as required by this Act on or before December 31, 2005.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2005.