CHAPTER 75

(House Bill 367)

AN ACT concerning

Maryland Medical Assistance Program – Primary Adult Care Program – ~~Selection of~~ Enrollment in a Managed Care Organization

FOR the purpose of requiring certain enrollees in the Primary Adult Care Program who become eligible for the HealthChoice Program to be enrolled automatically in a certain managed care organization under certain circumstances; requiring the Department of Health and Mental Hygiene to adopt certain regulations relating to the ~~selection of~~ enrollment of an individual in a managed care organization in the Primary Adult Care Program; making certain technical corrections; and generally relating to managed care organizations and the Maryland Medical Assistance Program.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 15–103(b)(1)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–103(b)(23) and 15–140
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

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

Article – Health – General

15–103.

(b) (1) As permitted by federal law or waiver, the Secretary may establish a program under which Program recipients are required to enroll in managed care organizations.

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

(ii) Program recipients shall have the right to choose:

1. The managed care organization with which they are enrolled; and

2. The primary care provider to whom they are assigned within the managed care organization.

(iii) If a recipient is disenrolled and reenrolls within 120 days of the recipient's disenrollment, the Department shall:

1. Assign the recipient to the managed care organization in which the recipient previously was enrolled; and

2. Require the managed care organization to assign the recipient to the primary care provider of record at the time of the recipient's disenrollment.

(iv) Whenever a recipient has to select a new managed care organization because the recipient's managed care organization has departed from the HealthChoice Program, the departing managed care organization:

1. Shall provide a written notice to the recipient 60 days before departing from the Program;

2. Shall include in the notice the name and provider number of the primary care provider assigned to the recipient and the telephone number of the enrollment broker; and

3. Within 30 days after departing from the Program, shall provide the Department with a list of enrollees and the name of each enrollee's primary care provider.

(v) On receiving the list provided by the managed care organization, the Department shall provide the list to:

1. The enrollment broker to assist and provide outreach to recipients in selecting a managed care organization; and

2. The remaining managed care organizations for the purpose of linking recipients with a primary care provider in accordance with federal law and regulation.

(vi) Subject to subsection (f)(4) and (5) of this section, an enrollee may disenroll from a managed care organization:

1. Without cause in the month following the anniversary date of the enrollee's enrollment; and

2. For cause, at any time as determined by the Secretary.

(VII) AN INDIVIDUAL WHO WAS ENROLLED IN THE PRIMARY ADULT CARE PROGRAM ESTABLISHED UNDER § 15–140 OF THIS SUBTITLE WITHIN 120 DAYS OF BECOMING ELIGIBLE FOR THE HEALTHCHOICE PROGRAM SHALL BE ENROLLED AUTOMATICALLY IN THE SAME MANAGED CARE ORGANIZATION IN WHICH THE INDIVIDUAL WAS ENROLLED UNDER THE PRIMARY ADULT CARE PROGRAM, IF THE MANAGED CARE ORGANIZATION IS PARTICIPATING IN THE HEALTHCHOICE PROGRAM.

15–140.

(a) In this section, **[**"Network"**] "PROGRAM"** means the Primary Adult Care **[**Network**] PROGRAM**.

(b) (1) There is a Primary Adult Care **[**Network**] PROGRAM** within the Program.

(2) The purpose of the Primary Adult Care **[**Network**] PROGRAM** is to:

(i) Consolidate health care services provided to adults through the Program; and

(ii) Access federal funding to expand primary and preventive care to adults lacking health care services.

(3) The Secretary shall administer the **[**Network**] PROGRAM** as allowed by federal law or waiver.

(c) Subject to the limitations of the State budget and as allowed by federal law or waiver, the **[**Network**]** **PROGRAM** shall provide a health care benefit package offering primary and preventive care for adults.

(d) The **[**Network**]** **PROGRAM** shall be funded:

(1) As provided in the State budget; and

(2) With federal matching money.

(e) The Secretary shall adopt regulations**:**

(1) **[**to**]** **TO** implement the **[**Network**]** **PROGRAM**; **AND**

~~**(2)** **THAT ALLOW APPLICANTS TO SELECT A PARTICIPATING MANAGED CARE ORGANIZATION WHEN APPLYING FOR THE PROGRAM;**~~

~~**(3)** **THAT REQUIRE THE DEPARTMENT TO ENROLL AN APPLICANT IN THE PARTICIPATING MANAGED CARE ORGANIZATION SELECTED BY THE APPLICANT;**~~

~~**(4)** **THAT REQUIRE THE DEPARTMENT TO SEND AN ENROLLMENT PACKET TO APPLICANTS WHO DO NOT SELECT A PARTICIPATING MANAGED CARE ORGANIZATION AT THE TIME OF THE APPLICATION; AND**~~

~~**(5)**~~ **(2)** **THAT** ~~**ESTABLISH**~~ **ESTABLISH A PROCESS THROUGH WHICH HISTORIC HEALTHCHOICE PROGRAM ENROLLEES WHO BECOME ELIGIBLE FOR THE PRIMARY ADULT CARE PROGRAM WITHIN 120 DAYS OF LOSING HEALTHCHOICE ELIGIBILITY WILL BE ENROLLED AUTOMATICALLY WITH THE SAME MANAGED CARE ORGANIZATION IN WHICH THE INDIVIDUAL WAS ENROLLED UNDER THE HEALTHCHOICE PROGRAM, IF THE MANAGED CARE ORGANIZATION IS PARTICIPATING IN THE PRIMARY ADULT CARE PROGRAM**.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2007.

Approved by the Governor, April 10, 2007.