HOUSE BILL 70

J1 9lr1402

By: ~~Delegate Morhaim~~ **Delegates Morhaim, Hammen, Pendergrass, Benson, Bromwell, Donoghue, Elliott, Kach, Kipke, Krebs, Kullen, McDonough, Montgomery, Nathan–Pulliam, Oaks, Pena–Melnyk, Reznik, Riley, Tarrant, V. Turner, and Weldon**

Introduced and read first time: January 16, 2009
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: February 18, 2009

CHAPTER _____

AN ACT concerning

Department of Health and Mental Hygiene – Commissions, Programs, and Reports – Revision

FOR the purpose of repealing provisions establishing the Community Services Advisory Commission; repealing the reporting requirement for the Department of Health and Mental Hygiene regarding the Substance Abuse Treatment Outcomes Partnership Fund; repealing the reporting requirement for certain facilities regarding the status of mentally ill individuals admitted to the facilities; repealing the reporting requirement for certain facilities regarding the release of mentally ill individuals from the facilities; repealing the reporting requirement for the Developmental Disabilities Administration regarding the implementation of community residential mental health programs for children and adolescents; repealing the reporting requirement for the State Advisory Council on Arthritis and Related Diseases; altering the reporting requirement for the Oral Health Safety Net Program; altering the reporting requirement for the Department regarding money held in trust from certain managed care organizations; repealing the reporting requirement for the Maryland Medical Advisory Committee; repealing the reporting requirement for the Department regarding the status of a certain waiver application; repealing a certain provision regarding eligibility for home– and community–based services for impaired individuals under Medicaid; repealing the reporting requirement for the Department regarding the status of an application for certain federal matching funds; repealing the reporting requirement for the Department

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

regarding the status of an application for a certain federal grant; repealing the community choice program; codifying certain provisions relating to the review and reporting of certain fee–for–service rates; repealing the reporting requirement of the Department regarding the Oral Health Program; repealing the requirement for a certain panel regarding off–label drug use; repealing the reporting requirement for the Department regarding the off–label drug use panel's recommendations; altering certain reporting requirements for the Department regarding fee–for–service rates; repealing certain reporting requirements for the Department regarding fee–for–service rates; repealing the reporting requirement of the Department regarding the results of certain hospital death record reviews; repealing a certain reporting requirement of the Department regarding dental services under the Maryland Medical Assistance Program; repealing the reporting requirement for the Department regarding the status of certain Family Investment Program recipients; repealing provisions establishing the Osteoporosis Prevention and Education Task Force; repealing the provisions establishing the State Advisory Council on Medical Privacy and Confidentiality; making technical corrections; and generally relating to the revision of commissions, programs, and reports of the Department of Health and Mental Hygiene.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 4–307(k)(1)(vi), 8–6C–03, 10–923(d), 10–925(c), 13–509, 13–2504, 15–102.4, 15–103(b)(27)(iv), 15–132(j), 15–133, and 24–1105(b)
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY repealing
Article – Health – General
Section 7–204, 10–711, 10–810, 15–130(f), 15–132(i) and (k), 15–141, and 18–803
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY adding to
Article – Health – General
Section 15–103.5
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–804
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY repealing
Chapter 280 of the Acts of the General Assembly of 2005

Section 11

BY repealing
Chapter 702 of the Acts of the General Assembly of 2001, as amended by Chapter 464 of the Acts of the General Assembly of 2002
Section 1

BY repealing
Chapter 1 of the Acts of the General Assembly of 1998
Section 2

BY repealing
Chapter 2 of the Acts of the General Assembly of 1998
Section 2

BY repealing
Chapter 113 of the Acts of the General Assembly of 1998
Section 6

BY repealing
Chapter 593 of the Acts of the General Assembly of 1997
Section 16

BY repealing
Article – Health – General
Section 4–3A–01 through 4–3A–05 and the subtitle "Subtitle 3A. State Advisory Council on Medical Privacy and Confidentiality"; and 13–1901 through 13–1906 and the subtitle "Subtitle 19. Osteoporosis Prevention and Education Task Force"
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY renumbering
Article – Health – General
Section 7–205 through 7–207, 10–712 through 10–714, and 10–811 through 10–813, respectively
to be Section 7–204 through 7–206, 10–711 through 10–713, and 10–810 through 10–812, respectively
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

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

Article – Health – General

4–307.

(k) (1) A health care provider shall disclose a medical record without the authorization of a person in interest:

(vi) In the event of the death of a recipient, to the office of the medical examiner as authorized under § 5–309 or **[**§ 10–714**]** § **10–713** of this article.

[7–204.

(a) To advance the public interest, it is the policy of this State:

(1) To eliminate over a 5–year period the number of mentally retarded and nonretarded developmentally disabled individuals who are on the waiting list for appropriate community services and programs; and

(2) To develop alternative ways and means to finance and expand existing services and programs within this time period.

(b) (1) There is a Community Services Advisory Commission within the Administration.

(2) The Commission consists of:

(i) 1 member of the Senate of Maryland, appointed by the President of the Senate, and 1 member of the House of Delegates, appointed by the Speaker of the House;

(ii) The Secretary or a designee;

(iii) The Director;

(iv) The Secretary of the Department of Budget and Management or a designee;

(v) 1 representative from the State Department of Education; and

(vi) 2 representatives from organizations that provide community program services, 2 representatives from the financial community, 2 representatives from advocacy–related organizations, and 1 member of the general public, appointed by the Governor.

(c) The Commission shall:

(1) Develop a systematic 5–year plan for:

(i) Identifying alternative funding mechanisms, including uses of State excess properties and proceeds derived from any sales or leases of the

properties, which enable community programs to serve all eligible mentally retarded and nonretarded developmentally disabled individuals;

(ii) Providing incentives to facilitate the establishment of new service providers for purposes consistent with this title;

(iii) Assuring appropriate levels of program accountability, monitoring, and quality control;

(iv) Evaluating appropriate personnel–related issues including compensation, recruitment, retention, professional training, and development; and

(v) Determining the effectiveness of any cost reimbursement system implemented by the Department and evaluating the need to maintain or modify the funding level in subsequent years;

(2) Monitor any implementation of the 5–year plan and make recommendations on how to facilitate further implementation; and

(3) Review Administration activities related to its services and programs.

(d) By July 1 of each year, the Commission shall:

(1) Update the systematic plan; and

(2) Report any findings and recommendations resulting from the annual update, the monitoring of plan implementation, and the review of Administration activities to the Governor, appropriate State agencies, and, subject to § 2–1246 of the State Government Article, the Legislative Policy Committee.**]**

8–6C–03.

[(a)**]** The Department shall adopt regulations to:

(1) Establish timelines and procedures for requests for Partnership funding, consistent with this subtitle;

(2) Establish guidelines that require programs to bill third–party insurers; and

(3) Manage the Fund and authorize distribution of money from the Fund in accordance with this subtitle.

[(b) On or before December 1 of each year, the Department shall issue a report to the Governor and, subject to § 2–1246 of the State Government Article, to the General Assembly evaluating the results of funded partnerships using the

performance and outcome indicators adopted by the Department and the Task Force to Study Increasing the Availability of Substance Abuse Programs.**]**

[10–711.

(a) Each facility that admits an individual under this title shall report to the Department on the status of the individual:

(1) At least once a year and, if requested by the Department, more often; and

(2) When the admission status of the individual changes.

(b) A status report shall:

(1) Be in the form that the Department requires; and

(2) Contain the information that the Department requires.**]**

[10–810.

(a) Each facility shall give the Department notice of the release of an individual who has been admitted to the facility under this title.

(b) The report shall:

(1) Be on the form that the Department requires; and

(2) Contain the information that the Department requires.**]**

10–923.

(d) Within 60 days after the Director receives an application for placement of a child or adolescent in a private therapeutic group home, the Director or the county health officer shall:

(1) Determine whether the child or adolescent meets the requirements for placement under this section; and

(2) If so:

(i) Approve the application for placement in a private therapeutic group home; and

(ii) Determine the date of placement in a private therapeutic group home in accordance with the **[**report**]** **PLAN** submitted under § 10–925 of this subtitle.

10–925.

(c) The Director shall:

(1) Implement §§ 10–920 through 10–924 and 10–926 of this subtitle upon completion of the plan to be submitted under this section; **AND**

(2) Review and revise periodically the plan submitted under this section**[**; and

(3) Submit an annual report to the Governor and, subject to § 2–1246 of the State Government Article, the President of the Senate and the Speaker of the House on the activities of the Administration to implement the plan, including any revision of the plan**]**.

13–509.

In addition to the powers and duties set forth elsewhere in this subtitle, the Advisory Council has the following powers and duties:

(1) To advise the Department on the implementation of the Program; **AND**

(2) To provide assistance to the Department in the development of the Program by:

(i) Recommending an integrated State program of education and applied research in gerontology and geriatrics;

(ii) Developing and coordinating programs in vocational rehabilitation and industry designed to assist individuals with arthritis to remain productive members of the State's workforce;

(iii) Coordinating the development of a strategic plan of patient education throughout the State, involving State and local health departments, private agencies, pharmaceutical companies, medical schools, and related professional organizations;

(iv) Addressing gaps in the delivery of State service and to make recommendations designed to contain costs associated with arthritis prevention, treatment, and vocational training;

(v) Coordinating the activities of public and private agencies, medical schools, and related professional groups to improve the quality of life for individuals with arthritis and their families; and

(vi) Making any other recommendations for carrying out the purposes of the Program as provided in § 13–504 of this subtitle**[**; and

(3) To submit a report annually to the Governor on the work of the Advisory Council**]**.

13–2504.

(a) (1) The Office of Oral Health shall conduct an annual evaluation of the Program.

(2) The evaluation required under this subsection shall include:

(i) Data on any progress resulting from each grant awarded under this subtitle;

(ii) Data on any progress of the overall Program;

(iii) Data demonstrating any increase in the use of restorative dental care among underserved populations; and

(iv) Data from any statewide survey conducted by the Department that demonstrates any progress of the Program.

(b) The **DEPARTMENT, IN CONJUNCTION WITH THE** Office of Oral **[**Health**]** **HEALTH,** shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on or before September 30 of each year on**:**

(1) [the**]** **THE** results of the Program**;**

(2) FINDINGS AND RECOMMENDATIONS FOR THE ORAL HEALTH PROGRAM AND ANY OTHER ORAL HEALTH PROGRAMS ESTABLISHED UNDER TITLE 18, SUBTITLE 8 OF THIS ARTICLE;

(3) THE AVAILABILITY AND ACCESSIBILITY OF DENTISTS THROUGHOUT THE STATE PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM;

(4) THE OUTCOMES THAT MANAGED CARE ORGANIZATIONS AND DENTAL MANAGED CARE ORGANIZATIONS UNDER THE MARYLAND MEDICAL ASSISTANCE PROGRAM ACHIEVE CONCERNING THE UTILIZATION OF TARGETS REQUIRED BY THE FIVE YEAR ORAL HEALTH CARE PLAN, INCLUDING:

(I) LOSS RATIOS THAT THE MANAGED CARE ORGANIZATIONS AND DENTAL MANAGED CARE ORGANIZATIONS EXPERIENCE FOR PROVIDING DENTAL SERVICES; AND

(II) CORRECTIVE ACTION BY MANAGED CARE ORGANIZATIONS AND DENTAL MANAGED CARE ORGANIZATIONS TO ACHIEVE THE UTILIZATION TARGETS; AND

(5) THE ALLOCATION AND USE OF FUNDS AUTHORIZED FOR DENTAL SERVICES UNDER THE MARYLAND MEDICAL ASSISTANCE PROGRAM.

15–102.4.

(a) (1) Each managed care organization shall be actuarially sound.

(2) (i) Except as otherwise provided in this section, the surplus that a managed care organization is required to have shall be paid in full.

(ii) A managed care organization shall have an initial surplus that exceeds the liabilities of the managed care organization by at least $1,500,000.

(b) (1) In consultation with the Secretary, the Insurance Commissioner may adjust the initial surplus requirement for a managed care organization that is not licensed as a health maintenance organization. In determining whether to make an adjustment under this paragraph, the Commissioner shall consider:

(i) The proposed capitation level that would be received by the managed care organization under a contract with the Department under this subtitle;

(ii) The proposed range of benefits to be provided under a contract with the Department under this subtitle;

(iii) The existence of any commitment by the Secretary to designate funds over and above the proposed capitation where the designated funds:

1. Are equivalent to the difference between the requirements of § 19–710 of this article and any lower requirements determined by the Commissioner under this subparagraph; and

2. Would be available in case of the impairment or insolvency of the managed care organization; and

(iv) The availability of the money held in trust by the Secretary to pay claims in case of impairment or insolvency of the managed care organization.

(2) Notwithstanding subsection (a)(2)(ii) of this section, a managed care organization shall have an initial surplus that exceeds liabilities by at least

$1,250,000. If a managed care organization has an initial surplus that is at least $1,250,000 but less than $1,500,000, prior to approval, the Department shall designate funds under paragraph (1)(iii) of this subsection sufficient to provide an initial surplus of at least $1,500,000.

(c) (1) (i) Each managed care organization shall maintain a surplus that exceeds the liabilities of the managed care organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the managed care organization with the Commissioner.

(ii) No managed care organization shall be required to maintain a surplus in excess of a value of $3,000,000.

(2) (i) For the protection of the managed care organization's enrollees and creditors, the applicant shall deposit and maintain in trust with the State Treasurer $100,000 in cash or government securities of the type described in § 5–701(b) of the Insurance Article.

(ii) 1. The deposits shall be accepted and held in trust by the State Treasurer in accordance with the provisions of Title 5, Subtitle 7 of the Insurance Article.

2. For the purpose of applying this subparagraph, a managed care organization shall be treated as an insurer.

(d) Each managed care organization shall comply with risk based capital standards in accordance with regulations adopted by the Insurance Commissioner under § 4–311 of the Insurance Article.

(e) **[**On**]** **IF THERE IS MONEY HELD IN TRUST UNDER THIS SECTION, ON** or before June 1 of each year, the Secretary shall submit to the General Assembly, in accordance with § 2–1246 of the State Government Article, a report on:

(1) The number of managed care organizations for which the Secretary has designated money to be held in trust under this section; and

(2) The amount of money held in trust by the Secretary that has been paid out in cases of insolvency or impairment of managed care organizations.

15–103.

(b) (27) (iv) In addition to any duties imposed by federal law and regulation, the Committee shall:

1. Advise the Secretary on the implementation, operation, and evaluation of managed care programs under this section;

2. Review and make recommendations on the regulations developed to implement managed care programs under this section;

3. Review and make recommendations on the standards used in contracts between the Department and managed care organizations;

4. Review and make recommendations on the Department's oversight of quality assurance standards;

5. Review data collected by the Department from managed care organizations participating in the Program and data collected by the Maryland Health Care Commission;

6. Promote the dissemination of managed care organization performance information, including loss ratios, to enrollees in a manner that facilitates quality comparisons and uses layman's language;

7. Assist the Department in evaluating the enrollment process; **AND**

8. Review reports of the ombudsmen**[**; and

9. Publish and submit an annual report to the Governor and, subject to § 2–1246 of the State Government Article, the General Assembly**]**.

15–103.5.

(A) FOR THE CALENDAR YEAR PRIOR TO THE REPORT DATE UNDER SUBSECTION (B) OF THIS SECTION, THE DEPARTMENT SHALL REVIEW THE RATES PAID TO PROVIDERS UNDER THE FEDERAL MEDICARE FEE SCHEDULE AND COMPARE THE RATES UNDER THE MEDICARE FEE SCHEDULE TO THE FEE–FOR–SERVICE RATES PAID TO SIMILAR PROVIDERS FOR THE SAME SERVICES UNDER THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE RATES PAID TO MANAGED CARE ORGANIZATION PROVIDERS FOR THE SAME SERVICES UNDER THE MARYLAND MEDICAL ASSISTANCE PROGRAM.

(B) ON OR BEFORE JANUARY 1, 2010, AND EACH JANUARY 1 THEREAFTER, THE DEPARTMENT SHALL REPORT, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE ON:

(1) THE REVIEW AND COMPARISON UNDER SUBSECTION (A) OF THIS SECTION;

(2) WHETHER THE FEE–FOR–SERVICE RATES AND MANAGED CARE ORGANIZATION PROVIDER RATES WILL EXCEED THE RATES PAID UNDER THE MEDICARE FEE SCHEDULE FOR THE PERIOD COVERED BY THE REVIEW REQUIRED UNDER SUBSECTION (A) OF THIS SECTION;

(3) AN ANALYSIS OF THE FEE–FOR–SERVICE REIMBURSEMENT RATES PAID IN OTHER STATES AND HOW THOSE RATES COMPARE WITH THOSE IN THE STATE;

(4) A SCHEDULE FOR BRINGING THE STATE'S FEE–FOR–SERVICE REIMBURSEMENT RATES TO A LEVEL THAT ASSURES THAT ALL HEALTH CARE PROVIDERS ARE REIMBURSED ADEQUATELY TO PROVIDE ACCESS TO CARE; AND

(5) AN ANALYSIS OF THE ESTIMATED COSTS OF IMPLEMENTING THE SCHEDULE AND ANY PROPOSED CHANGES TO THE FEE–FOR–SERVICE REIMBURSEMENT RATES FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM.

15–130.

[(f) Subject to § 2–1246 of the State Government Article, the Department shall report to the General Assembly every 6 months concerning the status of the Department's applications under subsection (b) of this section.**]**

15–132.

[(i) The proportion of individuals who qualify for medical assistance eligibility under the waiver under subsection (b) of this section who are residents of areas of the State described in § 15–141(b)(3) of this subtitle prior to implementation of the Program described in § 15–141 of this subtitle shall remain the same after implementation of the Program described in § 15–141 of this subtitle.**]**

[(j)**] (I)** The Department, in consultation with representatives of the affected industry and advocates for waiver candidates, and with the approval of the Department of Aging, shall adopt regulations to implement this section within 180 days of receipt of approval of the amended waiver application from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

[(k) Subject to § 2–1246 of the State Government Article, the Department shall report to the General Assembly every 6 months concerning the status of the Department's application under subsections (b) and (d) of this section.**]**

15–133.

(a) The State shall apply to the Health Care Financing Administration of the United States Department of Health and Human Services for grants to assist states in improving home and community–based service systems, including:

(1) Real choice system change grants;

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

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

(b) The Department shall seek input from eligible individuals, the individuals' representatives, and service providers in developing and implementing the Program.

(c) On or before July 1, 2001, the Department shall notify the Health Care Financing Administration of the United States Department of Health and Human Services of Maryland's intent to expand the current Medicaid home– and community–based waiver for adults with physical disabilities, under § 1915(c) of the federal Social Security Act to redirect funds to develop appropriate funding for this Program.

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

[15–141.

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

(2) "Community care organization" means an organization approved by the Department that arranges for health care services with the goal of promoting the delivery of services in the most appropriate, cost–effective setting.

(3) "Community choice program" means a program that delivers services in accordance with the waiver developed under this section.

(b) (1) On or before November 1, 2004, the Department shall apply for a waiver under the federal Social Security Act.

(2) As permitted by federal law or waiver, the Secretary may establish a program under which Maryland Medical Assistance Program recipients are required to enroll in community care organizations.

(3) Consistent with the federal waiver under paragraph (1) of this subsection, if the Secretary establishes a program under paragraph (2) of this subsection, the program may not operate in more than two areas of the State.

(c) Any waiver developed under this section shall include the following goals and objectives:

(1) Increasing participant satisfaction;

(2) Allowing participants to age in place;

(3) Reducing Medicaid expenditures by encouraging the most appropriate utilization of high quality services; and

(4) Enhancing compliance with the federal Americans with Disabilities Act by offering cost–effective community–based services in the most appropriate high quality and least restrictive setting.

(d) (1) The benefits provided by the community choice program shall include those services available under the Medicaid State Plan and services covered under home and community–based services waivers.

(2) Except when services are limited or excluded from the community choice program by the Secretary, the community care organization shall provide all the services established in regulation and required by the Secretary.

(3) The Secretary may exclude specific populations.

(4) The Secretary shall include a definition of "medical necessity" in its quality and access standards.

(5) Nothing in the community choice program may preclude a nursing home from utilizing an institutional pharmacy of its own choice for the provision of institutional pharmacy services and benefits for waiver enrollees in the nursing home.

(e) Community choice program recipients served by the program developed under this section shall be allowed to choose among at least two community care organizations that have demonstrated a network capacity sufficient to meet the needs of the population.

(f) (1) On an annual basis or for cause, an enrollee may choose to disenroll from a community care organization and enroll in another community care organization.

(2) Each enrollee receiving services in a nursing home, an assisted living facility, an adult day care facility, a psychiatric rehabilitation program, or a residential rehabilitation program shall have the option of remaining in the nursing

home, assisted living facility, adult day care facility, psychiatric rehabilitation program, or residential rehabilitation program.

(3) An enrollee of the program who qualifies for nursing level care may choose to receive services in a nursing home or in the community, if the community placement is cost–effective.

(4) The community choice program shall ensure that all enrollees in the program maintain access to pharmacy benefits, including all classes of drugs, that are comparable to the benefits provided in the Maryland Medical Assistance Program.

(g) (1) Each community care organization shall provide for the benefits described in subsection (d) of this section.

(2) This section may not be construed to prevent a community care organization from providing additional benefits that are not covered by a capitated rate.

(3) (i) The Department shall make capitation payments to each community care organization as provided in this paragraph.

(ii) The Secretary shall set capitation payments at a level that is actuarially adjusted for the benefits provided.

(iii) The Secretary shall adjust capitation payments to reflect the relative risk assumed by the community care organization.

(h) The Department shall require community care organizations to be certified to accept capitated payments from the federal Medicare program for individuals who are dually eligible.

(i) The community choice program shall include:

(1) Adults who are dually eligible;

(2) Adult Maryland Medical Assistance Program recipients who meet the nursing home level of care standard; and

(3) Maryland Medical Assistance Program recipients over 65 years of age.

(j) (1) Individuals eligible for the community choice program shall have the right to elect to receive services under the community choice program or an approved program of all–inclusive care for the elderly.

(2) If an individual eligible for the community choice program requires hospice care, the individual shall elect to receive hospice care from a licensed hospice program under a separate arrangement and payment for hospice care provided to the

individual shall be made directly to the hospice program by the Department under the Medicaid–established rate for hospice care reimbursement.

(3) If an individual eligible for the community choice program requires specialty mental health services, the individual shall elect to receive specialty mental health services from an approved mental health provider under a separate arrangement, and payment for specialty mental health services provided to the individual shall be made directly to the mental health provider by the Department under the Medicaid–established rate for specialty mental health services.

(k) (1) Each community care organization shall meet all requirements for certification by the Department.

(2) Each community care organization shall:

(i) Have a quality assurance program, subject to approval by the Secretary, which shall:

1. Provide for an enrollee grievance system, including an enrollee hotline;

2. Provide for a provider grievance system, including a provider hotline;

3. Provide for an enrollee satisfaction survey; and

4. Provide for a consumer advisory board to receive regular input from enrollees and submit an annual report of the advisory board to the Secretary;

(ii) Submit service–specific data in a format specified by the Secretary;

(iii) Include provisions for consumer direction of personal assistance services;

(iv) Ensure necessary provider capacity in all geographic regions where the community care organization is approved to operate;

(v) Be accountable, and hold its subcontractors accountable, for meeting all requirements, standards, criteria, or other directives of the Department and upon failure to meet those standards, be subject to one or more of the following penalties:

1. Fines;

2. Suspension of further enrollment;

3. Withholding of all or part of a capitation payment;

4. Termination of a contract;

5. Disqualification from future participation; and

6. Any other penalties that may be imposed by the Secretary;

(vi) Meet the solvency and capital requirements for HealthChoice managed care organizations under the Insurance Article;

(vii) To the extent practicable, allow waiver enrollees, who meet the nursing home level of care, to select a nursing home, assisted living facility, or adult day care facility provided that the nursing home, assisted living facility, or adult day care facility is licensed by the Department and the provider meets the Department–approved credentialing requirements of the community care organization;

(viii) Submit to the Department utilization and outcome reports as directed by the Department;

(ix) Provide timely access to, and continuity of, health and long–term care services for enrollees;

(x) Demonstrate organizational capacity to provide special population services, including outreach, case management, and home visiting, designed to meet the individual needs of all enrollees;

(xi) Provide assistance to enrollees in securing necessary health and long–term care services; and

(xii) Comply with all relevant provisions of the federal Balanced Budget Act of 1997 (P.L. 105–33).

(l) A community care organization may not have face–to–face or telephone contact or otherwise solicit an individual for the purpose of enrollment under the program.

(m) (1) In arranging for the benefits required under subsection (d) of this section, the community care organization shall:

(i) 1. Reimburse nursing homes not less than the Medicaid–established rate based on the waiver recipient's medical condition plus allowable ancillary services, as established by the Department based on its nursing home Medicaid rate setting methodology; or

2. For waiver recipients that would have been paid by the Medicare program for services provided, reimburse nursing homes not less than the applicable reimbursement rate payable by Medicare for that waiver recipient;

(ii) Reimburse nursing homes in accordance with the Department's policy on leave of absence as provided under § 15–117 of this subtitle;

(iii) Reimburse adult day care facilities not less than the rate determined by the Department for the Maryland Medical Assistance Program;

(iv) Reimburse hospitals in accordance with the rates established by the Health Services Cost Review Commission;

(v) For enrollees with complex, long–term care needs, use a comprehensive care and support management team, including the primary care provider, nurse manager, case manager, and others as appropriate; and

(vi) Reimburse a hospital emergency facility and provider for:

1. Health care services that meet the definition of emergency services under § 19–701 of this article;

2. Medical screening services rendered to meet the requirements of the federal Emergency Medical Treatment and Active Labor Act;

3. Medically necessary services if the community care organization authorized, referred, or otherwise allowed the enrollee to use the emergency facility and the medically necessary services are related to the condition for which the enrollee was allowed to use the emergency facility; and

4. Medically necessary services that relate to the condition presented and that are provided by the provider in the emergency facility to the enrollee if the community care organization fails to provide 24–hour access to a physician as required by the Department.

(2) A provider may not be required to obtain prior authorization or approval for payment from a community care organization in order to obtain reimbursement under paragraph (1)(vi) of this subsection.

(3) Nothing in this subsection prohibits a community care organization from providing a bonus or incentive for quality improvements.

(n) Savings from the program developed under this section shall be used to:

(1) Assist medically and functionally impaired individuals in the community, or when discharged from a hospital, to receive home– and community–based waiver services;

(2) Increase reimbursement rates to community providers; and

(3) Develop a statewide single point–of–entry system consisting of a designated entity in each county and Baltimore City to:

(i) Accept applications;

(ii) Make all eligibility determinations;

(iii) Enroll individuals in the program; and

(iv) Provide coordinated services, including:

1. Level–of–care determinations;

2. Financial determinations;

3. Plan of care determinations;

4. Case management services; and

5. Other services as needed.

(o) In developing the waiver application and regulations under this section, the Department shall solicit input from, and consult with, representatives of interested and affected parties, including:

(1) Legislators;

(2) Affected State agencies;

(3) Providers with expertise in dementia, geriatrics, end–of–life care, and mental health;

(4) Long–term care providers;

(5) Managed care organizations;

(6) Acute care providers;

(7) Lay care givers;

(8) Advocates for waiver–eligible candidates; and

(9) Consumers.

(p) In developing the waiver application under this section, the Department shall:

(1) Determine whether it is in the best interest of waiver enrollees to provide for a standard prescription drug formulary and drug utilization review for medically necessary drugs for waiver and nonwaiver recipients in nursing homes; and

(2) Consider maintaining the same nursing home prescription drug benefit and utilization review for all nursing home residents until federal implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(q) The Department shall, prior to applying to the Centers for Medicare and Medicaid Services for the waiver under this section, submit the proposed waiver to the Legislative Policy Committee for its review and comment.**]**

[18–803.

On or before December 1 of each year, the Secretary shall submit a report on its findings and recommendations to the Governor and, subject to § 2–1246 of the State Government Article, the General Assembly on the oral health programs established under this subtitle.**]**

24–1105.

(b) In accordance with an appropriation approved by the General Assembly in the State budget, the Comptroller shall transfer the investment earnings of:

(1) The Developmental Disabilities Administration account of the Trust Fund into the Waiting List Equity Fund established under **[**§ 7–206**]** § **7–205** of this article; and

(2) The Mental Hygiene Administration account of the Trust Fund into the Mental Hygiene Community–Based Services Fund established under § 10–208 of this article.

Article – Insurance

15–804.

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

(2) "Medical literature" means scientific studies published in a peer–reviewed national professional medical journal.

(3) "Off–label use" means the prescription of a drug for a treatment other than those treatments stated in the labeling approved by the federal Food and Drug Administration.

(4) "Standard reference compendia" means:

(i) the United States Pharmacopeia Drug Information;

(ii) the American Medical Association Drug Evaluations; and

(iii) the American Hospital Formulary Service Drug Information.

(b) This section does not:

(1) alter any law that limits the coverage of drugs that have not been approved by the federal Food and Drug Administration;

(2) require coverage of a drug if the federal Food and Drug Administration has determined use of the drug to be contraindicated; or

(3) require coverage of experimental drugs not approved for any indication by the federal Food and Drug Administration.

(c) (1) This subsection applies to each health insurance policy or contract that is delivered or issued for delivery in the State to an employer or individual on a group or individual basis, including a contract issued by a health maintenance organization.

(2) A policy or contract subject to this subsection that provides coverage for drugs may not exclude coverage of a drug for an off–label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.

(3) Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug.

(d) The Commissioner may direct a person, including a health maintenance organization, that issues a health insurance policy or contract to make payments required by this section.

[(e) (1) The Secretary of Health and Mental Hygiene shall appoint a panel of medical experts to review the off–label use of drugs not included in any of the standard reference compendia or in the medical literature and to advise the Secretary whether a particular off–label use of a drug is medically appropriate.

(2) The panel consists of:

(i) three medical oncologists chosen by the State Medical Oncology Association;

(ii) two specialists in the management of AIDS patients chosen by the State AIDS medical provider organizations;

(iii) one specialist in heart disease appointed by the University of Maryland Medical System; and

(iv) one physician chosen by the Medical and Chirurgical Faculty.

(3) The panel shall make recommendations periodically and whenever the Secretary of Health and Mental Hygiene is notified of a particular dispute about payment for an off–label use of a drug.

(4) Within 30 days after the panel's recommendations, the Secretary shall submit a written report on the recommendations to the Commissioner.**]**

Chapter 280 of the Acts of 2005

[SECTION 11. AND BE IT FURTHER ENACTED, That:

(a) For the calendar year prior to the report date under subsection (b) of this section, the Department of Health and Mental Hygiene shall review the rates paid to providers under the federal Medicare fee schedule and compare the rates under the Medicare fee schedule to the fee–for–service rates paid to similar providers for the same services under the Medical Assistance Program and the rates paid to managed care organization providers for the same services under the Medical Assistance Program.

(b) On or before January 1, 2006, and each January 1 thereafter, the Department shall report to the Senate Finance Committee and the House Health and Government Operations Committee on:

(1) the review and comparison under subsection (a) of this section; and

(2) whether the fee–for–service rates and managed care organization provider rates will exceed the rates paid under the Medicare fee schedule for the period covered by the report required under subsection (a) of this section.**]**

Chapter 702 of the Acts of 2001, as amended by Chapter 464 of the Acts of 2002

[SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) The Department of Health and Health and Mental Hygiene shall:

(1) establish a process to annually set the fee–for–service reimbursement rates for the Maryland Medical Assistance Program and the Maryland Children's Health Program in a manner that ensures participation of providers; and

(2) in developing the process required under item (1) of this subsection, consider:

(i) a reimbursement system that reflects reimbursement fee–for–service rates paid in the community as well as annual medical inflation; or

(ii) the current Resource Based Relative Value Scale system used in the federal Medicare program or the American Dental Association CDT–3 Codes.

(b) On or before September 1 of each year, the Department shall submit a report to the Governor and, in accordance with § 2–1246 of the State Government Article, to the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Environmental Matters Committee, and the House Appropriations Committee on:

(1) its progress in complying with subsection (a) of this section;

(2) an analysis of the fee–for–service reimbursement rates paid in other states and how those rates compare with those in Maryland;

(3) its schedule for bringing Maryland's fee–for–service reimbursement rates to a level that assures that all health care providers are reimbursed adequately to provide access to care; and

(4) an analysis on the estimated costs of implementing the schedule and any proposed changes to the fee–for–service reimbursement rates for the Maryland Medical Assistance Program and the Maryland Children's Health Program.**]**

Chapter 1 of the Acts of 1998

[SECTION 2. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall report to the General Assembly on or before January 1 of each year, in accordance with § 2–1246 of the State Government Article, on the results of hospital death record reviews conducted under § 19–310(l) of the Health – General Article.**]**

Chapter 2 of the Acts of 1998

[SECTION 2. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall report to the General Assembly on or before January 1 of each year, in accordance with § 2–1246 of the State Government Article, on the results

of hospital death record reviews conducted under § 19–310(l) of the Health – General Article.**]**

Chapter 113 of the Acts of 1998

[SECTION 6. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene, subject to § 2–1246 of the State Government Article, shall submit a report to the General Assembly annually concerning:

(1) the availability and accessibility of dentists throughout the State participating in the Maryland Medical Assistance Program;

(2) the outcomes that managed care organizations and dental managed care organizations under the Maryland Medical Assistance Program achieve concerning the utilization targets required by Section 2 of this Act, including:

(i) loss ratios that the managed care organizations and dental managed care organizations experience for providing dental services; and

(ii) corrective action by managed care organizations and dental managed care organizations to achieve the utilization targets; and

(3) the allocation and use of funds authorized by this Act.**]**

Chapter 593 of the Acts of 1997

[SECTION 16. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall report quarterly, subject to § 2–1312 of the State Government Article, to the Senate Finance Committee and the House Appropriations Committee on the status of Family Investment Program recipients referred to substance abuse treatment as a result of this Act.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That Section(s) 4–3A–01 through 4–3A–05 and the subtitle "Subtitle 3A. State Advisory Council on Medical Privacy and Confidentiality"; and 13–1901 through 13–1906 and the subtitle "Subtitle 19. Osteoporosis Prevention and Education Task Force" of Article – Health – General of the Annotated Code of Maryland be repealed.

SECTION 3. AND BE IT FURTHER ENACTED, That Section(s) 7–205 through 7–207, 10–712 through 10–714, and 10–811 through 10–813, respectively, of Article – Health – General of the Annotated Code of Maryland be renumbered to be Section(s) 7–204 through 7–206, 10–711 through 10–713, and 10–810 through 10–812, respectively.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2009.