

# HOUSE BILL 529

J1

6lr1200  
CF SB 244

---

By: **The Speaker (By Request – Department of Legislative Services – Code Revision)**

Introduced and read first time: January 27, 2026

Assigned to: Health

---

Committee Report: Favorable

House action: Adopted

Read second time: February 18, 2026

---

## CHAPTER \_\_\_\_\_

1 AN ACT concerning

2 **Code Revision – Health – Maryland Medical Assistance Program**

3 FOR the purpose of revising, restating, and recodifying the laws of this State relating to  
4 the Maryland Medical Assistance Program; and generally relating to laws relating  
5 to the Maryland Medical Assistance Program.

6 BY renumbering

7 Article – Health – General

8 Section 15–103.1 through 15–103.8

9 to be Section 15–103.3 through 15–103.10, respectively

10 Annotated Code of Maryland

11 (2023 Replacement Volume and 2025 Supplement)

12 BY repealing and reenacting, with amendments,

13 Article – Health – General

14 Section 5–615(c)(2)(vi), 15–102.5(a), 15–103, 15–109(b), 15–148, 15–152, 15–158,  
15 15–301(b)(1), and 15–304(b)(2)

16 Annotated Code of Maryland

17 (2023 Replacement Volume and 2025 Supplement)

18 BY adding to

19 Article – Health – General

20 Section 15–103.1, 15–103.2, and 15–305 through 15–309

21 Annotated Code of Maryland

---

**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.



1 (2023 Replacement Volume and 2025 Supplement)

2 BY repealing and reenacting, with amendments,  
3 Article – Health – General  
4 Section 15–103.5(b)(1) and 15–103.8(a)(2)  
5 Annotated Code of Maryland  
6 (2023 Replacement Volume and 2025 Supplement)  
7 (As enacted by Section 1 of this Act)

8 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,  
9 That Section(s) 15–103.1 through 15–103.8 of Article – Health – General of the Annotated  
10 Code of Maryland be renumbered to be Section(s) 15–103.3 through 15–103.10,  
11 respectively.

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

14 **Article – Health – General**

15 5–615.

16 (c) (2) The information sheet developed by the Department under this  
17 subsection shall be provided by:

18 (vi) A managed care organization in accordance with [§ 15–103] §  
19 **15–103.1(I)(1)(XVII)** of this article;

20 15–102.5.

21 (a) Subject to [§ 15–103(f)] § **15–103.1(DD)** of this subtitle, a health maintenance  
22 organization that requires its panel providers to participate in a managed care organization  
23 shall establish a mechanism, subject to review by the Secretary, which provides for  
24 equitable distribution of enrollees and which ensures that a provider will not be assigned a  
25 disproportionate number of enrollees.

26 15–103.

27 (a) [(1)] The Secretary shall administer the Maryland Medical Assistance  
28 Program.

29 [(2)] (B) The Program:

30 [(i)] (1) Subject to the limitations of the State budget, shall provide  
31 medical and other health care services for indigent individuals or medically indigent  
32 individuals or both;

1                    [(ii)] (2)        Shall provide, subject to the limitations of the State budget  
2 **AND AS PERMITTED BY FEDERAL LAW**, comprehensive medical, dental, and other health  
3 care services, including services provided in accordance with § 15–141.5 of this subtitle, for  
4 all eligible pregnant women whose family income is at or below [250 percent] **250%** of the  
5 poverty level for the duration of the pregnancy and for 1 year immediately following the  
6 end of the woman’s pregnancy[, as permitted by the federal law];

7                    [(iii)] (3)        Shall provide, subject to the limitations of the State budget  
8 **AND AS PERMITTED BY FEDERAL LAW**, comprehensive medical and other health care  
9 services for all eligible children currently under the age of 1 **YEAR** whose family income  
10 falls below [185 percent] **185%** of the poverty level[, as permitted by federal law];

11                   [(iv)] (4)        Beginning on January 1, 2012, shall provide, subject to the  
12 limitations of the State budget **AND AS PERMITTED BY FEDERAL LAW**, family planning  
13 services to all women whose family income is at or below [200 percent] **200%** of the poverty  
14 level[, as permitted by federal law];

15                   [(v)] (5)        Shall provide, subject to the limitations of the State budget  
16 **AND AS PERMITTED BY FEDERAL LAW**, comprehensive medical and other health care  
17 services for all children [from the age of] **WHO ARE AT LEAST** 1 year [up through and  
18 including] **OLD AND UNDER** the age of 5 years whose family income falls below [133  
19 percent] **133%** of the poverty level[, as permitted by the federal law];

20                   [(vi)] (6)        Beginning on January 1, 2014, shall provide, subject to the  
21 limitations of the State budget **AND AS PERMITTED BY FEDERAL LAW**, comprehensive  
22 medical care and other health care services for all children who are at least 6 years [of age  
23 but are] **OLD AND** under **THE AGE OF** 19 years [of age] whose family income falls below  
24 [133 percent] **133%** of the poverty level[, as permitted by federal law];

25                   [(vii)] (7)        Shall provide, subject to the limitations of the State budget  
26 **AND AS PERMITTED BY FEDERAL LAW**, comprehensive medical care and other health  
27 care services for all legal immigrants who meet Program eligibility standards and who  
28 arrived in the United States before August 22, 1996, the effective date of the federal  
29 Personal Responsibility and Work Opportunity Reconciliation Act[, as permitted by federal  
30 law];

31                   [(viii)] (8)        Shall provide, subject to the limitations of the State budget  
32 and any other requirements imposed by the State, comprehensive medical care and other  
33 health care services for all legal immigrant children under the age of 18 years and pregnant  
34 women who meet Program eligibility standards and who arrived in the United States on or  
35 after August 22, 1996, the effective date of the federal Personal Responsibility and Work  
36 Opportunity Reconciliation Act;

37                   [(ix)] (9)        Beginning on January 1, 2014, shall provide, subject to the  
38 limitations of the State budget, and as permitted by federal law, medical care and other

1 health care services for adults whose annual household income is at or below [133 percent]  
2 **133%** of the poverty level;

3 **[(x)] (10)** Subject to the limitations of the State budget, and as  
4 permitted by federal law:

5 **[1.] (I)** Shall provide comprehensive medical care, dental  
6 care, and other health care services for former foster care adolescents who, on their 18th  
7 birthday, were in foster care under the responsibility of the State and are not otherwise  
8 eligible for Program benefits; and

9 **[2.] (II)** May provide comprehensive medical care, dental  
10 care, and other health care services for former foster care adolescents who, on their 18th  
11 birthday, were in foster care under the responsibility of any other state or the District of  
12 Columbia;

13 **[(xi)] (11)** May include bedside nursing care for eligible Program  
14 recipients;

15 **[(xii)] (12)** Shall provide services in accordance with funding  
16 restrictions included in the annual State budget bill;

17 **[(xiii)] 1.** Beginning on January 1, 2019, may provide, subject to the  
18 limitations of the State budget, and as permitted by federal law, dental services for adults  
19 whose annual household income is at or below 133 percent of the poverty level; and]

20 **[2.] (13)** Beginning on January 1, 2023, shall provide,  
21 subject to the limitations of the State budget, and as permitted by federal law, dental  
22 services for adults, including diagnostic, preventive, restorative, and periodontal services,  
23 whose annual household income is at or below 133 percent of the federal poverty level;

24 **[(xiv)] (14)** Shall provide, subject to the limitations of the State  
25 budget, medically appropriate drugs that are approved by the United States Food and Drug  
26 Administration for the treatment of hepatitis C, regardless of the fibrosis score, and that  
27 are determined to be medically necessary;

28 **[(xv)] (15)** Shall provide, subject to the limitations of the State  
29 budget, health care services appropriately delivered through telehealth to a patient in  
30 accordance with § 15–141.2 of this subtitle;

31 **[(xvi)] (16)** Beginning on January 1, 2021, shall provide, subject to the  
32 limitations of the State budget and § 15–855(b)(2) of the Insurance Article, and as permitted  
33 by federal law, services for pediatric autoimmune neuropsychiatric disorders associated  
34 with streptococcal infections and pediatric acute onset neuropsychiatric syndrome,  
35 including the use of intravenous immunoglobulin therapy, for eligible Program recipients,  
36 if pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections

1 and pediatric acute onset neuropsychiatric syndrome are coded for billing and diagnosis  
2 purposes in accordance with § 15–855(d) of the Insurance Article;

3 [(xvii)] **(17)** Beginning on January 1, 2022, may not include, subject to  
4 federal approval and limitations of the State budget, a frequency limitation on covered  
5 dental prophylaxis care or oral health exams that requires the dental prophylaxis care or  
6 oral health exams to be provided at an interval greater than 120 days within a plan year;

7 [(xviii)] **(18)** Shall provide, subject to the limitations of the State  
8 budget, comprehensive medical care and other health care services to noncitizen pregnant  
9 women who would be eligible for the Program but for their immigration status and to their  
10 children up to the age of 1 year;

11 [(xix)] **(19)** Shall provide coverage of abortion care services to  
12 Program recipients in the manner described in § 15–857(b)(1)(ii) and (2) of the Insurance  
13 Article;

14 [(xx)] **(20)** Beginning on July 1, 2023, shall provide, subject to federal  
15 approval and limitations of the State budget, community violence prevention services in  
16 accordance with § 15–141.3 of this subtitle;

17 [(xxi)] **(21)** Beginning on January 1, 2023, shall provide, subject to the  
18 limitations of the State budget, and as permitted by federal law, coverage for self–measured  
19 blood pressure monitoring for all Program recipients diagnosed with uncontrolled high  
20 blood pressure, including:

21 [1.] **(I)** The provision of validated home blood pressure  
22 monitors; and

23 [2.] **(II)** Reimbursement of health care provider and other  
24 staff time used for patient training, transmission of blood pressure data, interpretation of  
25 blood pressure readings and reporting, and the delivery of co–interventions, including  
26 educational materials or classes, behavioral change management, and medication  
27 management;

28 [(xxii)] **(22)** Beginning on January 1, 2024, shall provide  
29 gender–affirming treatment in accordance with § 15–151 of this subtitle;

30 [(xxiii)] **(23)** Beginning on July 1, 2025, shall provide, subject to the  
31 limitations of the State budget, and as permitted by federal law, coverage for biomarker  
32 testing in accordance with § 15–859 of the Insurance Article;

33 [(xxiv)] **(24)** Beginning on January 1, 2025, shall provide coverage for  
34 prostheses in accordance with § 15–844 of the Insurance Article;

1            **[(xxv)] (25)** Beginning on January 1, 2026, shall provide, subject to the  
2 limitations of the State budget, and as permitted by federal law, coverage for self-measured  
3 blood pressure monitoring for eligible Program recipients in accordance with § 15-141.6 of  
4 this subtitle;

5            **[(xxvi)] (26)** Beginning on January 1, 2026, shall provide coverage for  
6 a transfer to a special pediatric hospital in accordance with § 15-861 of the Insurance  
7 Article;

8            **[(xxvii)] (27)** Beginning on January 1, 2026, if providing coverage  
9 for the delivery of anesthesia, shall provide coverage for the delivery of anesthesia in  
10 accordance with § 15-862 of the Insurance Article; and

11           **[(xxviii)] (28)** Beginning on January 1, 2026, shall provide  
12 calcium score testing in accordance with § 15-863 of the Insurance Article.

13           **[(3)] (C)** Subject to restrictions in federal law or waivers, the Department  
14 may:

15                 **[(i)] (1)** Impose cost-sharing on Program recipients; and

16                 **[(ii)] (2)** For adults who do not meet requirements for a federal  
17 category of eligibility for Medicaid:

18                         **[1.] (I)** Cap enrollment; and

19                         **[2.] (II)** Limit the benefit package.

20           **[(4)] (D)** Subject to the limitations of the State budget, the Department  
21 shall implement the provisions of Title II of the federal Patient Protection and Affordable  
22 Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010,  
23 to include:

24                 **[(i)] (1)** Parents and caretaker relatives who have a dependent  
25 child living in the parents' or caretaker relatives' home; and

26                 **[(ii)] (2)** Adults who do not meet requirements, such as age,  
27 disability, or parent or caretaker relative of a dependent child, for a federal category of  
28 eligibility for Medicaid and who are not enrolled in the federal Medicare program, as  
29 enacted by Title XVII of the Social Security Act.

30           **[(5)] (E)** **(1)** On or before January 1, 2025, subject to the limitations of  
31 the State budget, and as permitted by federal law, the Department:

32                         (i) Shall establish an Express Lane Eligibility Program to enroll  
33 individuals in the **[Maryland Medical Assistance]** Program and Maryland Children's

1 Health Program based on eligibility findings by the Supplemental Nutrition Assistance  
2 Program;

3 (ii) May not consider any other income or eligibility requirements;

4 (iii) To the extent that a waiver is needed to maximize the number of  
5 State residents who may qualify for the Express Lane Eligibility Program, shall apply to  
6 the Centers for Medicare and Medicaid Services for one or more waivers under § 1115 of  
7 the federal Social Security Act to implement the Express Lane Eligibility Program; and

8 (iv) [Shall] **SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION,**  
9 **SHALL** make all reasonable efforts to expedite enrollment of eligible individuals in the  
10 Express Lane Eligibility Program[, provided that the Department may propose or  
11 implement the use of Express Lane Eligibility for renewals before proposing or  
12 implementing the use of Express Lane Eligibility for initial enrollment].

13 **(2) THE DEPARTMENT MAY PROPOSE OR IMPLEMENT THE USE OF**  
14 **EXPRESS LANE ELIGIBILITY FOR RENEWALS BEFORE PROPOSING OR**  
15 **IMPLEMENTING THE USE OF EXPRESS LANE ELIGIBILITY FOR INITIAL**  
16 **ENROLLMENT.**

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

20 (2) (i) The benefits required by the program developed under  
21 paragraph (1) of this subsection shall be adopted by regulation and shall be equivalent to  
22 the benefit level required by the Maryland Medical Assistance Program on January 1, 1996.

23 (ii) Subject to the limitations of the State budget and as permitted  
24 by federal law or waiver, the Department shall provide reimbursement for medically  
25 necessary and appropriate inpatient, intermediate care, and halfway house substance  
26 abuse treatment services for substance abusing enrollees 21 years of age or older who are  
27 recipients of temporary cash assistance under the Family Investment Program.

28 (iii) Each managed care organization participating in the program  
29 developed under paragraph (1) of this subsection shall provide or arrange for the provision  
30 of the benefits described in subparagraph (ii) of this paragraph.

31 (iv) Nothing in this paragraph may be construed to prohibit a  
32 managed care organization from offering additional benefits, if the managed care  
33 organization is not receiving capitation payments based on the provision of the additional  
34 benefits.

1 (v) Notwithstanding subparagraph (i) of this paragraph, the benefits  
2 required by the program developed under paragraph (1) of this subsection shall include  
3 dental services for pregnant women.

4 (3) Subject to the limitations of the State budget and as permitted by  
5 federal law or waiver, the program developed under paragraph (1) of this subsection and  
6 the program developed under § 15–301 of this title may provide guaranteed eligibility for  
7 each enrollee for up to 6 months, unless an enrollee obtains health insurance through  
8 another source.

9 (4) (i) The Secretary may exclude specific populations or services from  
10 the program developed under paragraph (1) of this subsection.

11 (ii) For any populations or services excluded under this paragraph,  
12 the Secretary may authorize a managed care organization, to provide the services or  
13 provide for the population, including authorization of a separate dental managed care  
14 organization or a managed care organization to provide services to Program recipients with  
15 special needs.

16 (5) (i) Except for a service excluded by the Secretary under paragraph  
17 (4) of this subsection, each managed care organization shall provide all the benefits  
18 required by regulations adopted under paragraph (2) of this subsection.

19 (ii) For a population or service excluded by the Secretary under  
20 paragraph (4) of this subsection, the Secretary may authorize a managed care organization  
21 to provide only for that population or provide only that service.

22 (iii) A managed care organization may subcontract specified required  
23 services to a health care provider that is licensed or authorized to provide those services.

24 (6) Except for the Program of All-inclusive Care for the Elderly (“PACE”)  
25 Program, the Secretary may not include the long-term care population or long-term care  
26 services in the program developed under paragraph (1) of this subsection.

27 (7) The program developed under paragraph (1) of this subsection shall  
28 ensure that enrollees have access to a pharmacy that:

29 (i) Is licensed in the State; and

30 (ii) Is within a reasonable distance from the enrollee’s residence.

31 (8) For cause, the Department may disenroll enrollees from a managed  
32 care organization and enroll them in another managed care organization.

33 (9) Each managed care organization shall:

1 (i) Have a quality assurance program in effect which is subject to  
2 the approval of the Department and which, at a minimum:

3 1. Complies with any health care quality improvement  
4 system developed by the Centers for Medicare and Medicaid Services;

5 2. Complies with the quality requirements of applicable  
6 State licensure laws and regulations;

7 3. Complies with practice guidelines and protocols specified  
8 by the Department;

9 4. Provides for an enrollee grievance system, including an  
10 enrollee hotline;

11 5. Provides a provider grievance system;

12 6. Provides for enrollee and provider satisfaction surveys, to  
13 be taken at least annually;

14 7. Provides for a consumer advisory board to receive regular  
15 input from enrollees;

16 8. Provides for an annual consumer advisory board report to  
17 be submitted to the Secretary; and

18 9. Complies with specific quality, access, data, and  
19 performance measurements adopted by the Department for treating enrollees with special  
20 needs;

21 (ii) Submit to the Department:

22 1. Service-specific data by service type in a format to be  
23 established by the Department;

24 2. Utilization and outcome reports, such as the Health Plan  
25 Employer Data and Information Set (HEDIS), as directed by the Department; and

26 3. At least semiannually, aggregate data that includes:

27 A. The number of enrollees provided with substance abuse  
28 treatment services; and

29 B. The amount of money spent on substance abuse  
30 treatment;

- 1 (iii) Promote timely access to and continuity of health care services  
2 for enrollees;
- 3 (iv) Demonstrate organizational capacity to provide special  
4 programs, including outreach, case management, and home visiting, tailored to meet the  
5 individual needs of all enrollees;
- 6 (v) Provide assistance to enrollees in securing necessary health care  
7 services;
- 8 (vi) Provide or assure alcohol and drug abuse treatment for  
9 substance abusing pregnant women and all other enrollees of managed care organizations  
10 who require these services;
- 11 (vii) Educate enrollees on health care prevention and good health  
12 habits;
- 13 (viii) Assure necessary provider capacity in all geographic areas under  
14 contract;
- 15 (ix) Be accountable and hold its subcontractors accountable for  
16 standards established by the Department and, upon failure to meet those standards, be  
17 subject to one or more of the following penalties:
- 18 1. Fines;
  - 19 2. Suspension of further enrollments;
  - 20 3. Withholding of all or part of the capitation payment;
  - 21 4. Termination of the contract;
  - 22 5. Disqualification from future participation in the Program;
  - 23 and
  - 24 6. Any other penalties that may be imposed by the  
25 Department;
- 26 (x) Subject to applicable federal and State law, include incentives for  
27 enrollees to comply with provisions of the managed care organization;
- 28 (xi) Provide or arrange to provide primary mental health services;
- 29 (xii) Provide or arrange to provide all Medicaid-covered services  
30 required to comply with State statutes and regulations mandating health and mental  
31 health services for children in State supervised care;

1 1. According to standards set by the Department; and

2 2. Locally, to the extent the services are available locally;

3 (xiii) Submit to the Department aggregate information from the  
4 quality assurance program, including complaints and resolutions from the enrollee and  
5 provider grievance systems, the enrollee hotline, and enrollee satisfaction surveys;

6 (xiv) Maintain as part of the enrollee's medical record the following  
7 information:

8 1. The basic health risk assessment conducted on  
9 enrollment;

10 2. Any information the managed care organization receives  
11 that results from an assessment of the enrollee conducted for the purpose of any early  
12 intervention, evaluation, planning, or case management program;

13 3. Information from the local department of social services  
14 regarding any other service or benefit the enrollee receives, including assistance or benefits  
15 from a program administered by the Department of Human Services under the Human  
16 Services Article; and

17 4. Any information the managed care organization receives  
18 from a school-based clinic, a core services agency, a local health department, or any other  
19 person that has provided health services to the enrollee;

20 (xv) Upon provision of information specified by the Department  
21 under paragraph (19) of this subsection, pay school-based clinics for services provided to  
22 the managed care organization's enrollees;

23 (xvi) In coordination with participating dentists, enrollees, and  
24 families of enrollees, develop a process to arrange to provide dental therapeutic treatment  
25 to individuals under 21 years of age that requires:

26 1. A participating dentist to notify a managed care  
27 organization when an enrollee is in need of therapeutic treatment and the dentist is unable  
28 to provide the treatment;

29 2. A managed care organization to provide the enrollee or the  
30 family of the enrollee with a list of participating providers who offer therapeutic dental  
31 services; and

32 3. A managed care organization to notify the enrollee or the  
33 family of the enrollee that the managed care organization will provide further assistance if  
34 the enrollee has difficulty obtaining an appointment with a provider of therapeutic dental  
35 services;

1 (xvii) Provide the advance directive information sheet developed under  
2 § 5–615 of this article:

3 1. To all enrollees at the time of initial enrollment and in the  
4 managed care organization’s enrollee publications;

5 2. If the managed care organization maintains a website, on  
6 the managed care organization’s website; and

7 3. At the request of an enrollee; and

8 (xviii) If a managed care organization maintains a website, after the tab  
9 on the State–designated health information exchange website required under §  
10 19–145(b)(2)(iv) of this article is developed, provide a link to the webpage that is accessed  
11 through the tab.

12 (10) The Department shall adopt regulations that assure that managed care  
13 organizations employ appropriate personnel to:

14 (i) Assure that individuals with special needs obtain needed  
15 services; and

16 (ii) Coordinate those services.

17 (11) (i) A managed care organization shall reimburse a hospital  
18 emergency facility and provider for:

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

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

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

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

31 (ii) A provider may not be required to obtain prior authorization or  
32 approval for payment from a managed care organization in order to obtain reimbursement  
33 under this paragraph.

1 (12) (i) Each managed care organization shall notify each enrollee when  
2 the enrollee should obtain an immunization, examination, or other wellness service.

3 (ii) Each managed care organization shall:

4 1. Maintain evidence of compliance with paragraph (9) of  
5 this subsection; and

6 2. Provide to the Department, upon initial application to  
7 provide health care services to enrollees and on an annual basis thereafter, evidence of  
8 compliance with paragraph (9) of this subsection, including submission of a written plan.

9 (iii) A managed care organization that does not comply with  
10 subparagraph (i) of this paragraph for at least 90% of its new enrollees:

11 1. Within 90 days of their enrollment may not receive more  
12 than 80% of its capitation payments;

13 2. Within 180 days of their enrollment may not receive more  
14 than 70% of its capitation payments; and

15 3. Within 270 days of their enrollment may not receive more  
16 than 50% of its capitation payments.

17 (iv) If a managed care organization does not comply with the  
18 requirements of paragraph (9) of this subsection, the Department may contract with any  
19 community-based health organization that the Department determines is willing and able  
20 to perform comprehensive outreach services to enrollees.

21 (v) In addition to the provisions of subparagraph (iv) of this  
22 paragraph, if a managed care organization does not comply with the requirements of  
23 paragraph (9) of this subsection or fails to provide evidence of compliance to the Department  
24 under subparagraph (ii) of this paragraph, the Department may:

25 1. Impose a fine on the managed care organization which  
26 shall be deposited in the HealthChoice Performance Incentive Fund established under §  
27 15-103.3 of this subtitle;

28 2. Suspend further enrollment into the managed care  
29 organization;

30 3. Withhold all or part of the capitation rate from the  
31 managed care organization;

32 4. Terminate the provider agreement; or

1                               5.     Disqualify the managed care organization from future  
2 participation in the Maryland Medicaid Managed Care Program.

3                               (13)   The Department shall:

4                               (i)     Establish and maintain an ombudsman program and a locally  
5 accessible enrollee hotline;

6                               (ii)    Perform focused medical reviews of managed care organizations  
7 that include reviews of how the managed care organizations are providing health care  
8 services to special populations;

9                               (iii)   Provide timely feedback to each managed care organization on  
10 its compliance with the Department's quality and access system;

11                              (iv)    Establish and maintain within the Department a process for  
12 handling provider complaints about managed care organizations; and

13                              (v)    Adopt regulations relating to appeals by managed care  
14 organizations of penalties imposed by the Department, including regulations providing for  
15 an appeal to the Office of Administrative Hearings.

16                              (14) (i)    Except as provided in subparagraph (iii) of this paragraph, the  
17 Department shall delegate responsibility for maintaining the ombudsman program for a  
18 county to that county's local health department on the request of the local health  
19 department.

20                              (ii)    A local health department may not subcontract the ombudsman  
21 program.

22                              (iii)   Before the Department delegates responsibility to a local health  
23 department to maintain the ombudsman program for a county, a local health department  
24 that is also a Medicaid provider must receive the approval of the Secretary and the local  
25 governing body.

26                              (15)   A managed care organization may not:

27                              (i)     Without authorization by the Department, enroll an individual  
28 who at the time is a Program recipient; or

29                              (ii)    Have face-to-face or telephone contact, or otherwise solicit with  
30 an individual who at the time is a Program recipient before the Program recipient enrolls  
31 in the managed care organization unless:

32                                       1.     Authorized by the Department; or

33                                       2.     The Program recipient initiates contact.

1           (16) (i) The Department shall be responsible for enrolling Program  
2 recipients into managed care organizations.

3           (ii) The Department may contract with an entity to perform the  
4 enrollment function.

5           (iii) The Department or its enrollment contractor shall administer a  
6 health risk assessment developed by the Department to ensure that individuals who need  
7 special or immediate health care services will receive the services on a timely basis.

8           (iv) The Department or its enrollment contractor:

9                   1. May administer the health risk assessment only after the  
10 Program recipient has chosen a managed care organization; and

11                   2. Shall forward the results of the health risk assessment to  
12 the managed care organization chosen by the Program recipient within 5 business days.

13           (17) For a managed care organization with which the Secretary contracts to  
14 provide services to Program recipients under this subsection, the Secretary shall establish  
15 a mechanism to initially assure that each historic provider that meets the Department's  
16 quality standards has the opportunity to continue to serve Program recipients as a  
17 subcontractor of at least one managed care organization.

18           (18) (i) The Department shall make capitation payments to each  
19 managed care organization as provided in this paragraph.

20           (ii) In consultation with the Insurance Commissioner, the Secretary  
21 shall:

22                   1. Set capitation payments at a level that is actuarially  
23 adjusted to the benefits provided; and

24                   2. Actuarially adjust the capitation payments to reflect the  
25 relative risk assumed by the managed care organization.

26           (iii) In actuarially adjusting capitation payments under  
27 subparagraph (ii)2 of this paragraph, the Secretary, in consultation with the Insurance  
28 Commissioner, shall take into account, to the extent allowed under federal law, the  
29 expenses incurred by the managed care organization applicable to the business of providing  
30 care to enrolled individuals.

31           (19) (i) School-based clinics and managed care organizations shall  
32 collaborate to provide continuity of care to enrollees.

1 (ii) School-based clinics shall be defined by the Department in  
2 consultation with the State Department of Education.

3 (iii) Each managed care organization shall require a school-based  
4 clinic to provide to the managed care organization certain information, as specified by the  
5 Department, about an encounter with an enrollee of the managed care organization prior  
6 to paying the school-based clinic.

7 (iv) Upon receipt of information specified by the Department, the  
8 managed care organization shall pay, at Medicaid-established rates, school-based clinics  
9 for covered services provided to enrollees of the managed care organization.

10 (v) The Department shall work with managed care organizations  
11 and school-based clinics to develop collaboration standards, guidelines, and a process to  
12 assure that the services provided are covered and medically appropriate and that the  
13 process provides for timely notification among the parties.

14 (vi) Each managed care organization shall maintain records of all  
15 health care services:

- 16 1. Provided to its enrollees by school-based clinics; and
- 17 2. For which the managed care organization has been billed.

18 (20) The Department shall establish standards for the timely delivery of  
19 services to enrollees.

20 (21) (i) The Department shall establish a delivery system for specialty  
21 mental health services for enrollees of managed care organizations.

22 (ii) The Behavioral Health Administration shall:

- 23 1. Design and monitor the delivery system;
- 24 2. Establish performance standards for providers in the  
25 delivery system; and
- 26 3. Establish procedures to ensure appropriate and timely  
27 referrals from managed care organizations to the delivery system that include:
  - 28 A. Specification of the diagnoses and conditions eligible for  
29 referral to the delivery system;
  - 30 B. Training and clinical guidance in appropriate use of the  
31 delivery system for managed care organization primary care providers;

1 C. Preauthorization by the utilization review agent of the  
2 delivery system; and

3 D. Penalties for a pattern of improper referrals.

4 (iii) The Department shall collaborate with managed care  
5 organizations to develop standards and guidelines for the provision of specialty mental  
6 health services.

7 (iv) The delivery system shall:

8 1. Provide all specialty mental health services needed by  
9 enrollees;

10 2. For enrollees who are dually diagnosed, coordinate the  
11 provision of substance use disorder services provided by the managed care organizations of  
12 the enrollees;

13 3. Consist of a network of qualified mental health  
14 professionals from all core disciplines;

15 4. Include linkages with other public service systems; and

16 5. Comply with quality assurance, enrollee input, data  
17 collection, and other requirements specified by the Department in regulation.

18 (v) The Department may contract with a managed care organization  
19 for delivery of specialty mental health services if the managed care organization meets the  
20 performance standards adopted by the Department in regulations.

21 (vi) The provisions of § 15–1005 of the Insurance Article apply to the  
22 delivery system for specialty mental health services established under this paragraph and  
23 administered by an administrative services organization.

24 (vii) The Department and the Behavioral Health Administration  
25 shall ensure that the delivery system has an adequate network of providers available to  
26 provide substance use disorder treatment for children under the age of 18 years.

27 (22) The Department shall include a definition of medical necessity in its  
28 quality and access standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



- 1 G. Individuals who are homeless or have experienced  
2 homelessness;
- 3 H. Individuals enrolled in home- and community-based  
4 services waivers;
- 5 I. Elderly individuals;
- 6 J. Low-income individuals and individuals receiving  
7 benefits through the Temporary Assistance for Needy Families Program; and
- 8 K. Individuals receiving substance abuse treatment services;
- 9 5. Two members of the Finance Committee of the Senate of  
10 Maryland, appointed by the President of the Senate; and
- 11 6. Three members of the Maryland House of Delegates,  
12 appointed by the Speaker of the House.
- 13 (iii) A designee of each of the following shall serve as an ex-officio  
14 member of the Committee:
- 15 1. The Secretary of Human Services;
- 16 2. The Executive Director of the Maryland Health Care  
17 Commission; and
- 18 3. The Maryland Association of County Health Officers.
- 19 (iv) In addition to any duties imposed by federal law and regulation,  
20 the Committee shall:
- 21 1. Advise the Secretary on the implementation, operation,  
22 and evaluation of managed care programs under this section;
- 23 2. Review and make recommendations on the regulations  
24 developed to implement managed care programs under this section;
- 25 3. Review and make recommendations on the standards used  
26 in contracts between the Department and managed care organizations;
- 27 4. Review and make recommendations on the Department's  
28 oversight of quality assurance standards;
- 29 5. Review data collected by the Department from managed  
30 care organizations participating in the Program and data collected by the Maryland Health  
31 Care Commission;

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

4                                   7.     Assist the Department in evaluating the enrollment  
5 process; and

6                                   8.     Review reports of the ombudsmen.

7                                   (v)    Except as specified in subparagraphs (ii) and (iii) of this  
8 paragraph, the members of the Maryland Medicaid Advisory Committee shall be appointed  
9 by the Secretary and serve for a 4-year term.

10                                  (vi)   In making appointments to the Committee, the Secretary shall  
11 provide for continuity and rotation.

12                                  (vii)  In appointing consumer members to the Committee, the  
13 Secretary shall seek recommendations from:

14                                   1.     The State Protection and Advocacy System Organization;

15                                   2.     The Statewide Independent Living Council;

16                                   3.     The Developmental Disabilities Council;

17                                   4.     The Department of Disabilities;

18                                   5.     The Department of Aging;

19                                   6.     Consumer advocacy organizations; and

20                                   7.     The public.

21                                  (viii) The Secretary shall appoint the chair of the Committee.

22                                  (ix)   The Secretary shall appoint nonvoting members from managed  
23 care organizations who may participate in Committee meetings, unless the Committee  
24 meets in closed session as provided in § 3-305 of the General Provisions Article.

25                                  (x)    The Department shall provide staff for the Committee.

26                                  (xi)   The Committee shall determine the times and places of its  
27 meetings.

28                                  (xii)  1.     The chair of the Committee and the staff for the  
29 Committee shall provide the agenda, minutes, and any written materials to be presented

1 or discussed at a meeting to the members of the Committee at least 5 days prior to the  
2 meeting.

3                   2. The agenda, minutes, and written materials shall be  
4 provided to members of the Committee in a manner and format that reasonably  
5 accommodates the specific needs of the member.

6                   (xiii) 1. Except as provided in subsubparagraph 2 of this  
7 subparagraph, a member of the Committee:

8                   A. May not receive compensation; but

9                   B. Is entitled to reimbursement for expenses under the  
10 Standard State Travel Regulations, as provided in the State budget.

11                   2. A member of the Committee who is an enrollee is entitled  
12 to reimbursement for:

13                   A. Expenses for personal and dependent care incurred during  
14 the meeting and during travel time to and from the meeting;

15                   B. Expenses for cognitive supports related to the meeting;  
16 and

17                   C. Appropriate transportation to and from the meeting.

18                   3. On request, the Department shall provide for a dedicated  
19 Department staff person:

20                   A. To review meeting materials with enrollee members in  
21 advance of a meeting by telephone or in person; and

22                   B. To provide referrals to advocacy organizations.]

23                   [(28) (i)] **(F)**       **(1)** The Department shall ensure that payments for  
24 services provided by a hospital located in a contiguous state or in the District of Columbia  
25 to an enrollee under the Program shall be reduced by 20% if the hospital fails to submit  
26 discharge data on all Maryland patients receiving care in the hospital to the Health  
27 Services Cost Review Commission in a form and manner the Commission specifies.

28                   [(ii)] **(2)**       [Subparagraph (i) of this paragraph] **PARAGRAPH (1) OF**  
29 **THIS SUBSECTION** does not apply to a hospital that presently provides discharge data to  
30 the public in a form the Health Services Cost Review Commission determines is  
31 satisfactory.

32                   [(29) A managed care organization shall provide coverage for hearing loss  
33 screenings of newborns provided by a hospital before discharge.

1 (30) (i) The Department shall provide enrollees and health care  
2 providers with an accurate directory or other listing of all available providers:

3 1. In written form, made available upon request; and

4 2. On an Internet database.

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

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

9 (31) Paragraph (9)(xvii) of this subsection may not be construed to require a  
10 managed care organization to:

11 (i) Assist an enrollee in drafting an electronic advance care  
12 planning document;

13 (ii) Store electronic advance care planning documents; or

14 (iii) Access advance care planning documents.

15 (32) A managed care organization may not apply a prior authorization  
16 requirement for a prescription drug used as postexposure prophylaxis for the prevention of  
17 HIV if the prescription drug is prescribed for use in accordance with Centers for Disease  
18 Control and Prevention guidelines.

19 (33) The Secretary shall adopt regulations for pharmacy benefits managers  
20 that contract with managed care organizations that establish requirements for conducting  
21 audits of pharmacies or pharmacists that are:

22 (i) To the extent practicable, substantively similar to the audit  
23 provisions under § 15–1629 of the Insurance Article; and

24 (ii) Consistent with federal law.]

25 **[(c)] (G)** (1) (i) In this subsection the following words have the meanings  
26 indicated.

27 (ii) “Certified nurse practitioner” means a registered nurse who is  
28 licensed in this State, has completed a nurse practitioner program approved by the State  
29 Board of Nursing, and has passed an examination approved by that Board.

30 (iii) “Nurse anesthetist” means a registered nurse who is:

1                                   1.       Certified under the Health Occupations Article to practice  
2 nurse anesthesia; and

3                                   2.       Certified by the Council on Certification or the Council on  
4 Recertification of Nurse Anesthetists.

5                                   (iv)   “Nurse midwife” means a registered nurse who is licensed in this  
6 State and has been certified by the American College of Nurse–Midwives as a nurse  
7 midwife.

8                                   (v)   “Optometrist” has the meaning stated in § 11–101 of the Health  
9 Occupations Article.

10                               (2)   The Secretary may contract for the provision of care under the Program  
11 to eligible Program recipients.

12                               (3)   The Secretary may contract with insurance companies or nonprofit  
13 health service plans or with individuals, associations, partnerships, incorporated or  
14 unincorporated groups of physicians, chiropractors, dentists, podiatrists, optometrists,  
15 pharmacists, hospitals, nursing homes, nurses, including nurse anesthetists, nurse  
16 midwives and certified nurse practitioners, opticians, and other health practitioners who  
17 are licensed or certified in this State and perform services on the prescription or referral of  
18 a physician.

19                               (4)   For the purposes of this section, the nurse midwife need not be under  
20 the supervision of a physician.

21                               (5)   Except as otherwise provided by law, a contract that the Secretary  
22 makes under this subsection shall continue unless terminated under the terms of the  
23 contract by the Program or by the provider.

24                               **[(d)] (H)**   As permitted by federal law or waiver, the Secretary may administer  
25 the Medicare Option Prescription Drug Program, established under § 15–124.3 of this  
26 subtitle, as part of the Maryland Medical Assistance Program.

27                               **[(e)] (I)**   By regulation, the Department shall adopt a methodology to ensure  
28 that federally qualified health centers are paid reasonable cost–based reimbursement that  
29 is consistent with federal law.

30                               **[(f)] (1)**   The Department shall establish mechanisms for:

31                                   (i)   Identifying a Program recipient’s primary care provider at the  
32 time of enrollment into a managed care program; and

33                                   (ii)   Maintaining continuity of care with the primary care provider if:

1                   1.     The provider has a contract with a managed care  
2 organization or a contracted medical group of a managed care organization to provide  
3 primary care services; and

4                   2.     The recipient desires to continue care with the provider.

5                   (2)    If a Program recipient enrolls in a managed care organization and  
6 requests assignment to a particular primary care provider who has a contract with the  
7 managed care organization or a contracted group of the managed care organization, the  
8 managed care organization shall assign the recipient to the primary care provider.

9                   (3)    A Program recipient may request a change of primary care providers  
10 within the same managed care organization at any time and, if the primary care provider  
11 has a contract with the managed care organization or a contracted group of the managed  
12 care organization, the managed care organization shall honor the request.

13                  (4)    In accordance with the federal Health Care Financing Administration's  
14 guidelines, a Program recipient may elect to disenroll from a managed care organization if  
15 the managed care organization terminates its contract with the Department.

16                  (5)    A Program recipient may disenroll from a managed care organization  
17 to maintain continuity of care with a primary care provider if:

18                  (i)    The contract between the primary care provider and the  
19 managed care organization or contracted group of the managed care organization  
20 terminates because:

21                   1.     The managed care organization or contracted group of the  
22 managed care organization terminates the provider's contract for a reason other than  
23 quality of care or the provider's failure to comply with contractual requirements related to  
24 quality assurance activities;

25                   2.     A.     The managed care organization or contracted group  
26 of the managed care organization reduces the primary care provider's capitated or  
27 applicable fee for services rates;

28                   B.     The reduction in rates is greater than the actual change in  
29 rates or capitation paid to the managed care organization by the Department; and

30                   C.     The provider and the managed care organization or  
31 contracted group of the managed care organization are unable to negotiate a mutually  
32 acceptable rate; or

33                   3.     The provider contract between the provider and the  
34 managed care organization is terminated because the managed care organization is  
35 acquired by another entity; and

1 (ii) 1. The Program recipient desires to continue to receive care  
2 from the primary care provider;

3 2. The provider contracts with at least one other managed  
4 care organization or contracted group of a managed care organization; and

5 3. The enrollee notifies the Department or the Department's  
6 designee of the enrollee's intention within 90 days after the contract termination.

7 (6) The Department shall provide timely notification to the affected  
8 managed care organization of an enrollee's intention to disenroll under the provisions of  
9 paragraph (5) of this subsection.]

10 **15-103.1.**

11 (A) AS PERMITTED BY FEDERAL LAW OR WAIVER, THE SECRETARY MAY  
12 ESTABLISH A PROGRAM UNDER WHICH PROGRAM RECIPIENTS ARE REQUIRED TO  
13 ENROLL IN MANAGED CARE ORGANIZATIONS.

14 (B) (1) THE BENEFITS REQUIRED BY THE PROGRAM DEVELOPED UNDER  
15 SUBSECTION (A) OF THIS SECTION SHALL BE:

16 (I) ADOPTED BY REGULATION; AND

17 (II) AT LEAST EQUIVALENT TO THE BENEFIT LEVEL REQUIRED  
18 BY THE PROGRAM ON JANUARY 1, 1996.

19 (2) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND AS  
20 PERMITTED BY FEDERAL LAW OR WAIVER, THE DEPARTMENT SHALL PROVIDE  
21 REIMBURSEMENT FOR MEDICALLY NECESSARY AND APPROPRIATE INPATIENT,  
22 INTERMEDIATE CARE, AND HALFWAY HOUSE SUBSTANCE USE DISORDER  
23 TREATMENT SERVICES FOR ENROLLEES AT LEAST 21 YEARS OLD WITH SUBSTANCE  
24 USE DISORDERS WHO ARE RECIPIENTS OF TEMPORARY CASH ASSISTANCE UNDER  
25 THE FAMILY INVESTMENT PROGRAM.

26 (3) EACH MANAGED CARE ORGANIZATION PARTICIPATING IN THE  
27 PROGRAM DEVELOPED UNDER SUBSECTION (A) OF THIS SECTION SHALL PROVIDE  
28 OR ARRANGE FOR THE PROVISION OF THE BENEFITS DESCRIBED IN PARAGRAPH (2)  
29 OF THIS SUBSECTION.

30 (4) THIS SUBSECTION MAY NOT BE CONSTRUED TO PROHIBIT A  
31 MANAGED CARE ORGANIZATION FROM OFFERING ADDITIONAL BENEFITS IF THE  
32 MANAGED CARE ORGANIZATION IS NOT RECEIVING CAPITATION PAYMENTS BASED  
33 ON THE PROVISION OF THE ADDITIONAL BENEFITS.

1           **(5) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, THE**  
2 **BENEFITS REQUIRED BY THE PROGRAM DEVELOPED UNDER SUBSECTION (A) OF**  
3 **THIS SECTION SHALL INCLUDE DENTAL SERVICES FOR PREGNANT WOMEN.**

4           **(C) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND AS**  
5 **PERMITTED BY FEDERAL LAW OR WAIVER, THE PROGRAM DEVELOPED UNDER**  
6 **SUBSECTION (A) OF THIS SECTION MAY PROVIDE GUARANTEED ELIGIBILITY FOR**  
7 **EACH ENROLLEE FOR UP TO 6 MONTHS UNLESS AN ENROLLEE OBTAINS HEALTH**  
8 **INSURANCE THROUGH ANOTHER SOURCE.**

9           **(D) (1) THE SECRETARY MAY EXCLUDE SPECIFIC POPULATIONS OR**  
10 **SERVICES FROM THE PROGRAM DEVELOPED UNDER SUBSECTION (A) OF THIS**  
11 **SECTION.**

12           **(2) FOR ANY POPULATIONS OR SERVICES EXCLUDED UNDER THIS**  
13 **SUBSECTION, THE SECRETARY MAY AUTHORIZE A MANAGED CARE ORGANIZATION**  
14 **TO PROVIDE THE SERVICES OR PROVIDE FOR THE POPULATION, INCLUDING**  
15 **AUTHORIZATION OF A SEPARATE DENTAL MANAGED CARE ORGANIZATION OR A**  
16 **MANAGED CARE ORGANIZATION TO PROVIDE SERVICES TO PROGRAM RECIPIENTS**  
17 **WITH SPECIAL NEEDS.**

18           **(E) (1) EXCEPT FOR A SERVICE EXCLUDED BY THE SECRETARY UNDER**  
19 **SUBSECTION (D) OF THIS SECTION, EACH MANAGED CARE ORGANIZATION SHALL**  
20 **PROVIDE ALL THE BENEFITS REQUIRED BY REGULATIONS ADOPTED UNDER**  
21 **SUBSECTION (B) OF THIS SECTION.**

22           **(2) FOR A POPULATION OR SERVICE EXCLUDED BY THE SECRETARY**  
23 **UNDER SUBSECTION (D) OF THIS SECTION, THE SECRETARY MAY AUTHORIZE A**  
24 **MANAGED CARE ORGANIZATION TO PROVIDE ONLY FOR THAT POPULATION OR**  
25 **PROVIDE ONLY THAT SERVICE.**

26           **(3) A MANAGED CARE ORGANIZATION MAY SUBCONTRACT SPECIFIED**  
27 **REQUIRED SERVICES TO A HEALTH CARE PROVIDER THAT IS LICENSED OR**  
28 **AUTHORIZED TO PROVIDE THOSE SERVICES.**

29           **(F) EXCEPT FOR THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE**  
30 **ELDERLY (“PACE”) PROGRAM, THE SECRETARY MAY NOT INCLUDE THE**  
31 **LONG-TERM CARE POPULATION OR LONG-TERM CARE SERVICES IN THE PROGRAM**  
32 **DEVELOPED UNDER SUBSECTION (A) OF THIS SECTION.**

33           **(G) THE PROGRAM DEVELOPED UNDER SUBSECTION (A) OF THIS SECTION**  
34 **SHALL ENSURE THAT ENROLLEES HAVE ACCESS TO A PHARMACY THAT:**

1           **(1) IS LICENSED IN THE STATE; AND**

2           **(2) IS WITHIN A REASONABLE DISTANCE FROM THE ENROLLEE'S**  
3 **RESIDENCE.**

4           **(H) FOR CAUSE, THE DEPARTMENT MAY DISENROLL ENROLLEES FROM A**  
5 **MANAGED CARE ORGANIZATION AND ENROLL THEM IN ANOTHER MANAGED CARE**  
6 **ORGANIZATION.**

7           **(I) (1) EACH MANAGED CARE ORGANIZATION SHALL:**

8                   **(I) HAVE A QUALITY ASSURANCE PROGRAM IN EFFECT THAT IS**  
9 **SUBJECT TO THE APPROVAL OF THE DEPARTMENT AND THAT, AT A MINIMUM:**

10                           **1. COMPLIES WITH ANY HEALTH CARE QUALITY**  
11 **IMPROVEMENT SYSTEM DEVELOPED BY THE CENTERS FOR MEDICARE AND**  
12 **MEDICAID SERVICES;**

13                           **2. COMPLIES WITH THE QUALITY REQUIREMENTS OF**  
14 **APPLICABLE STATE LICENSURE LAWS AND REGULATIONS;**

15                           **3. COMPLIES WITH PRACTICE GUIDELINES AND**  
16 **PROTOCOLS SPECIFIED BY THE DEPARTMENT;**

17                           **4. PROVIDES FOR AN ENROLLEE GRIEVANCE SYSTEM,**  
18 **INCLUDING AN ENROLLEE HOTLINE;**

19                           **5. PROVIDES FOR A PROVIDER GRIEVANCE SYSTEM;**

20                           **6. PROVIDES FOR ENROLLEE AND PROVIDER**  
21 **SATISFACTION SURVEYS, TO BE TAKEN AT LEAST ANNUALLY;**

22                           **7. PROVIDES FOR A CONSUMER ADVISORY BOARD TO**  
23 **RECEIVE REGULAR INPUT FROM ENROLLEES;**

24                           **8. PROVIDES FOR AN ANNUAL CONSUMER ADVISORY**  
25 **BOARD REPORT TO BE SUBMITTED TO THE SECRETARY; AND**

26                           **9. COMPLIES WITH SPECIFIC QUALITY, ACCESS, DATA,**  
27 **AND PERFORMANCE MEASUREMENTS ADOPTED BY THE DEPARTMENT FOR**  
28 **TREATING ENROLLEES WITH SPECIAL NEEDS;**

**(II) SUBMIT TO THE DEPARTMENT:**

**1. SERVICE-SPECIFIC DATA BY SERVICE TYPE IN A FORMAT ESTABLISHED BY THE DEPARTMENT;**

**2. UTILIZATION AND OUTCOME REPORTS, SUCH AS THE HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS), AS DIRECTED BY THE DEPARTMENT; AND**

**3. AT LEAST SEMIANNUALLY, AGGREGATE DATA THAT INCLUDES:**

**A. THE NUMBER OF ENROLLEES PROVIDED WITH SUBSTANCE USE DISORDER TREATMENT SERVICES; AND**

**B. THE AMOUNT OF MONEY SPENT ON SUBSTANCE USE DISORDER TREATMENT;**

**(III) PROMOTE TIMELY ACCESS TO AND CONTINUITY OF HEALTH CARE SERVICES FOR ENROLLEES;**

**(IV) DEMONSTRATE ORGANIZATIONAL CAPACITY TO PROVIDE SPECIAL PROGRAMS, INCLUDING OUTREACH, CASE MANAGEMENT, AND HOME VISITING, TAILORED TO MEET THE INDIVIDUAL NEEDS OF ALL ENROLLEES;**

**(V) PROVIDE ASSISTANCE TO ENROLLEES IN SECURING NECESSARY HEALTH CARE SERVICES;**

**(VI) PROVIDE OR ENSURE SUBSTANCE USE DISORDER TREATMENT FOR PREGNANT WOMEN WITH SUBSTANCE USE DISORDERS AND ALL OTHER ENROLLEES OF THE MANAGED CARE ORGANIZATION WHO REQUIRE THESE SERVICES;**

**(VII) EDUCATE ENROLLEES ON HEALTH CARE PREVENTION AND GOOD HEALTH HABITS;**

**(VIII) ENSURE NECESSARY PROVIDER CAPACITY IN ALL GEOGRAPHIC AREAS UNDER CONTRACT;**

**(IX) BE ACCOUNTABLE AND HOLD ITS SUBCONTRACTORS ACCOUNTABLE FOR STANDARDS ESTABLISHED BY THE DEPARTMENT AND, ON FAILURE TO MEET THOSE STANDARDS, BE SUBJECT TO ONE OR MORE OF THE FOLLOWING PENALTIES:**

- 1                           1.    **FINES;**
- 2                           2.    **SUSPENSION OF FURTHER ENROLLMENTS;**
- 3                           3.    **WITHHOLDING OF ALL OR PART OF THE CAPITATION**  
4 **PAYMENT;**
- 5                           4.    **TERMINATION OF THE CONTRACT;**
- 6                           5.    **DISQUALIFICATION FROM FUTURE PARTICIPATION IN**  
7 **THE PROGRAM; AND**
- 8                           6.    **ANY OTHER PENALTIES THAT MAY BE IMPOSED BY**  
9 **THE DEPARTMENT;**

10                           (X)   **SUBJECT TO APPLICABLE FEDERAL AND STATE LAW,**  
11 **INCLUDE INCENTIVES FOR ENROLLEES TO COMPLY WITH PROVISIONS OF THE**  
12 **MANAGED CARE ORGANIZATION;**

13                           (XI)  **PROVIDE OR ARRANGE TO PROVIDE PRIMARY MENTAL**  
14 **HEALTH SERVICES;**

15                           (XII) **PROVIDE OR ARRANGE TO PROVIDE ALL**  
16 **MEDICAID-COVERED SERVICES REQUIRED TO COMPLY WITH STATE STATUTES AND**  
17 **REGULATIONS MANDATING HEALTH AND MENTAL HEALTH SERVICES FOR CHILDREN**  
18 **IN STATE-SUPERVISED CARE:**

19                           1.    **ACCORDING TO STANDARDS SET BY THE**  
20 **DEPARTMENT; AND**

21                           2.    **LOCALLY, TO THE EXTENT THE SERVICES ARE**  
22 **AVAILABLE LOCALLY;**

23                           (XIII) **SUBMIT TO THE DEPARTMENT AGGREGATE INFORMATION**  
24 **FROM THE QUALITY ASSURANCE PROGRAM, INCLUDING COMPLAINTS AND**  
25 **RESOLUTIONS FROM THE ENROLLEE AND PROVIDER GRIEVANCE SYSTEMS, THE**  
26 **ENROLLEE HOTLINE, AND ENROLLEE SATISFACTION SURVEYS;**

27                           (XIV) **MAINTAIN AS PART OF THE ENROLLEE'S MEDICAL RECORD**  
28 **THE FOLLOWING INFORMATION:**

1                   1.     **THE BASIC HEALTH RISK ASSESSMENT CONDUCTED**  
2 **ON ENROLLMENT;**

3                   2.     **ANY INFORMATION THE MANAGED CARE**  
4 **ORGANIZATION RECEIVES THAT RESULTS FROM AN ASSESSMENT OF THE ENROLLEE**  
5 **CONDUCTED FOR THE PURPOSE OF ANY EARLY INTERVENTION, EVALUATION,**  
6 **PLANNING, OR CASE MANAGEMENT PROGRAM;**

7                   3.     **INFORMATION FROM THE LOCAL DEPARTMENT OF**  
8 **SOCIAL SERVICES REGARDING ANY OTHER SERVICE OR BENEFIT THE ENROLLEE**  
9 **RECEIVES, INCLUDING ASSISTANCE OR BENEFITS FROM A PROGRAM ADMINISTERED**  
10 **BY THE DEPARTMENT OF HUMAN SERVICES UNDER THE HUMAN SERVICES**  
11 **ARTICLE; AND**

12                   4.     **ANY INFORMATION THE MANAGED CARE**  
13 **ORGANIZATION RECEIVES FROM A SCHOOL-BASED CLINIC, A CORE SERVICES**  
14 **AGENCY, A LOCAL HEALTH DEPARTMENT, OR ANY OTHER PERSON THAT HAS**  
15 **PROVIDED HEALTH SERVICES TO THE ENROLLEE;**

16                   (xv) **ON PROVISION OF INFORMATION SPECIFIED BY THE**  
17 **DEPARTMENT UNDER SUBSECTION (R)(3) OF THIS SECTION, PAY SCHOOL-BASED**  
18 **CLINICS FOR SERVICES PROVIDED TO THE MANAGED CARE ORGANIZATION'S**  
19 **ENROLLEES;**

20                   (xvi) **IN COORDINATION WITH PARTICIPATING DENTISTS,**  
21 **ENROLLEES, AND FAMILIES OF ENROLLEES, DEVELOP A PROCESS TO ARRANGE TO**  
22 **PROVIDE DENTAL THERAPEUTIC TREATMENT TO INDIVIDUALS UNDER THE AGE OF**  
23 **21 YEARS THAT REQUIRES:**

24                   1.     **A PARTICIPATING DENTIST TO NOTIFY A MANAGED**  
25 **CARE ORGANIZATION WHEN AN ENROLLEE IS IN NEED OF THERAPEUTIC**  
26 **TREATMENT AND THE DENTIST IS UNABLE TO PROVIDE THE TREATMENT;**

27                   2.     **THE MANAGED CARE ORGANIZATION TO PROVIDE**  
28 **THE ENROLLEE OR THE FAMILY OF THE ENROLLEE WITH A LIST OF PARTICIPATING**  
29 **PROVIDERS WHO OFFER THERAPEUTIC DENTAL SERVICES; AND**

30                   3.     **THE MANAGED CARE ORGANIZATION TO NOTIFY THE**  
31 **ENROLLEE OR THE FAMILY OF THE ENROLLEE THAT THE MANAGED CARE**  
32 **ORGANIZATION WILL PROVIDE FURTHER ASSISTANCE IF THE ENROLLEE HAS**  
33 **DIFFICULTY OBTAINING AN APPOINTMENT WITH A PROVIDER OF THERAPEUTIC**  
34 **DENTAL SERVICES;**

1 (XVII) PROVIDE THE ADVANCE DIRECTIVE INFORMATION SHEET  
2 DEVELOPED UNDER § 5-615 OF THIS ARTICLE:

3 1. TO ALL ENROLLEES AT THE TIME OF INITIAL  
4 ENROLLMENT AND IN THE MANAGED CARE ORGANIZATION'S ENROLLEE  
5 PUBLICATIONS;

6 2. IF THE MANAGED CARE ORGANIZATION MAINTAINS A  
7 WEBSITE, ON THE MANAGED CARE ORGANIZATION'S WEBSITE; AND

8 3. AT THE REQUEST OF AN ENROLLEE; AND

9 (XVIII) IF THE MANAGED CARE ORGANIZATION MAINTAINS A  
10 WEBSITE, PROVIDE A LINK TO THE WEBPAGE THAT IS ACCESSED THROUGH THE TAB  
11 ON THE STATE-DESIGNATED HEALTH INFORMATION EXCHANGE WEBSITE  
12 REQUIRED UNDER § 19-145.1(B)(2)(IV) OF THIS ARTICLE.

13 (2) PARAGRAPH (1)(XVII) OF THIS SUBSECTION MAY NOT BE  
14 CONSTRUED TO REQUIRE A MANAGED CARE ORGANIZATION TO:

15 (I) ASSIST AN ENROLLEE IN DRAFTING AN ELECTRONIC  
16 ADVANCE CARE PLANNING DOCUMENT;

17 (II) STORE ELECTRONIC ADVANCE CARE PLANNING  
18 DOCUMENTS; OR

19 (III) ACCESS ADVANCE CARE PLANNING DOCUMENTS.

20 (3) (I) EACH MANAGED CARE ORGANIZATION SHALL NOTIFY EACH  
21 ENROLLEE WHEN THE ENROLLEE SHOULD OBTAIN AN IMMUNIZATION,  
22 EXAMINATION, OR OTHER WELLNESS SERVICE.

23 (II) EACH MANAGED CARE ORGANIZATION SHALL:

24 1. MAINTAIN EVIDENCE OF COMPLIANCE WITH  
25 PARAGRAPH (1) OF THIS SUBSECTION; AND

26 2. ON INITIAL APPLICATION TO PROVIDE HEALTH CARE  
27 SERVICES TO ENROLLEES AND ON AN ANNUAL BASIS THEREAFTER, PROVIDE TO THE  
28 DEPARTMENT EVIDENCE OF COMPLIANCE WITH PARAGRAPH (1) OF THIS  
29 SUBSECTION INCLUDING SUBMISSION OF A WRITTEN PLAN.

1 (III) A MANAGED CARE ORGANIZATION THAT DOES NOT COMPLY  
2 WITH PARAGRAPH (1) OF THIS SUBSECTION FOR AT LEAST 90% OF ITS NEW  
3 ENROLLEES:

4 1. WITHIN 90 DAYS OF THEIR ENROLLMENT MAY NOT  
5 RECEIVE MORE THAN 80% OF ITS CAPITATION PAYMENTS;

6 2. WITHIN 180 DAYS OF THEIR ENROLLMENT MAY NOT  
7 RECEIVE MORE THAN 70% OF ITS CAPITATION PAYMENTS; AND

8 3. WITHIN 270 DAYS OF THEIR ENROLLMENT MAY NOT  
9 RECEIVE MORE THAN 50% OF ITS CAPITATION PAYMENTS.

10 (IV) IF A MANAGED CARE ORGANIZATION DOES NOT COMPLY  
11 WITH THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, THE  
12 DEPARTMENT MAY CONTRACT WITH ANY COMMUNITY-BASED HEALTH  
13 ORGANIZATION THAT THE DEPARTMENT DETERMINES IS WILLING AND ABLE TO  
14 PERFORM COMPREHENSIVE OUTREACH SERVICES TO ENROLLEES.

15 (V) IN ADDITION TO THE PROVISIONS OF SUBPARAGRAPH (IV)  
16 OF THIS PARAGRAPH, IF A MANAGED CARE ORGANIZATION DOES NOT COMPLY WITH  
17 THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION OR FAILS TO PROVIDE  
18 EVIDENCE OF COMPLIANCE TO THE DEPARTMENT UNDER SUBPARAGRAPH (II) OF  
19 THIS PARAGRAPH, THE DEPARTMENT MAY:

20 1. IMPOSE A FINE ON THE MANAGED CARE  
21 ORGANIZATION;

22 2. SUSPEND FURTHER ENROLLMENT INTO THE  
23 MANAGED CARE ORGANIZATION;

24 3. WITHHOLD ALL OR PART OF THE CAPITATION RATE  
25 FROM THE MANAGED CARE ORGANIZATION;

26 4. TERMINATE THE PROVIDER AGREEMENT; OR

27 5. DISQUALIFY THE MANAGED CARE ORGANIZATION  
28 FROM FUTURE PARTICIPATION IN THE PROGRAM ESTABLISHED UNDER SUBSECTION  
29 (A) OF THIS SECTION.

30 (VI) THE DEPARTMENT SHALL DEPOSIT FINES IMPOSED UNDER  
31 SUBPARAGRAPH (V)1 OF THIS PARAGRAPH IN THE HEALTHCHOICE PERFORMANCE  
32 INCENTIVE FUND ESTABLISHED UNDER § 15-103.5 OF THIS SUBTITLE.

1           **(J) THE DEPARTMENT SHALL ADOPT REGULATIONS THAT ENSURE THAT**  
2 **MANAGED CARE ORGANIZATIONS EMPLOY APPROPRIATE PERSONNEL TO:**

3                   **(1) ENSURE THAT INDIVIDUALS WITH SPECIAL NEEDS OBTAIN**  
4 **NEEDED SERVICES; AND**

5                   **(2) COORDINATE THOSE SERVICES.**

6           **(K) (1) A MANAGED CARE ORGANIZATION SHALL REIMBURSE A HOSPITAL**  
7 **EMERGENCY FACILITY AND PROVIDER FOR:**

8                   **(I) HEALTH CARE SERVICES THAT MEET THE DEFINITION OF**  
9 **EMERGENCY SERVICES IN § 19-701 OF THIS ARTICLE;**

10                   **(II) MEDICAL SCREENING SERVICES RENDERED TO MEET THE**  
11 **REQUIREMENTS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE**  
12 **LABOR ACT;**

13                   **(III) MEDICALLY NECESSARY SERVICES IF THE MANAGED CARE**  
14 **ORGANIZATION AUTHORIZED, REFERRED, OR OTHERWISE ALLOWED THE ENROLLEE**  
15 **TO USE THE EMERGENCY FACILITY AND THE MEDICALLY NECESSARY SERVICES ARE**  
16 **RELATED TO THE CONDITION FOR WHICH THE ENROLLEE WAS ALLOWED TO USE THE**  
17 **EMERGENCY FACILITY; AND**

18                   **(IV) MEDICALLY NECESSARY SERVICES THAT RELATE TO THE**  
19 **CONDITION PRESENTED AND THAT ARE PROVIDED BY THE PROVIDER IN THE**  
20 **EMERGENCY FACILITY TO THE ENROLLEE IF THE MANAGED CARE ORGANIZATION**  
21 **FAILS TO PROVIDE 24-HOUR ACCESS TO A PHYSICIAN AS REQUIRED BY THE**  
22 **DEPARTMENT.**

23                   **(2) A PROVIDER MAY NOT BE REQUIRED TO OBTAIN PRIOR**  
24 **AUTHORIZATION OR APPROVAL FOR PAYMENT FROM A MANAGED CARE**  
25 **ORGANIZATION IN ORDER TO OBTAIN REIMBURSEMENT UNDER THIS SUBSECTION.**

26           **(L) THE DEPARTMENT SHALL:**

27                   **(1) ESTABLISH AND MAINTAIN AN OMBUDSMAN PROGRAM AND A**  
28 **LOCALLY ACCESSIBLE ENROLLEE HOTLINE;**

29                   **(2) PERFORM FOCUSED MEDICAL REVIEWS OF MANAGED CARE**  
30 **ORGANIZATIONS THAT INCLUDE REVIEWS OF HOW THE MANAGED CARE**

1 ORGANIZATIONS ARE PROVIDING HEALTH CARE SERVICES TO SPECIAL  
2 POPULATIONS;

3 (3) PROVIDE TIMELY FEEDBACK TO EACH MANAGED CARE  
4 ORGANIZATION ON ITS COMPLIANCE WITH THE DEPARTMENT'S QUALITY AND  
5 ACCESS SYSTEM;

6 (4) ESTABLISH AND MAINTAIN WITHIN THE DEPARTMENT A PROCESS  
7 FOR HANDLING PROVIDER COMPLAINTS ABOUT MANAGED CARE ORGANIZATIONS;  
8 AND

9 (5) ADOPT REGULATIONS RELATING TO APPEALS BY MANAGED CARE  
10 ORGANIZATIONS OF PENALTIES IMPOSED BY THE DEPARTMENT, INCLUDING  
11 REGULATIONS PROVIDING FOR AN APPEAL TO THE OFFICE OF ADMINISTRATIVE  
12 HEARINGS.

13 (M) (1) SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, THE  
14 DEPARTMENT SHALL DELEGATE RESPONSIBILITY FOR MAINTAINING THE  
15 OMBUDSMAN PROGRAM FOR A COUNTY TO THAT COUNTY'S LOCAL HEALTH  
16 DEPARTMENT ON THE REQUEST OF THE LOCAL HEALTH DEPARTMENT.

17 (2) A LOCAL HEALTH DEPARTMENT MAY NOT SUBCONTRACT THE  
18 OMBUDSMAN PROGRAM.

19 (3) BEFORE THE DEPARTMENT DELEGATES RESPONSIBILITY TO A  
20 LOCAL HEALTH DEPARTMENT TO MAINTAIN THE OMBUDSMAN PROGRAM FOR A  
21 COUNTY, A LOCAL HEALTH DEPARTMENT THAT IS ALSO A MEDICAID PROVIDER  
22 MUST RECEIVE THE APPROVAL OF THE SECRETARY AND THE LOCAL GOVERNING  
23 BODY.

24 (N) A MANAGED CARE ORGANIZATION MAY NOT:

25 (1) WITHOUT AUTHORIZATION BY THE DEPARTMENT, ENROLL AN  
26 INDIVIDUAL WHO AT THE TIME IS A PROGRAM RECIPIENT; OR

27 (2) HAVE FACE-TO-FACE OR TELEPHONE CONTACT WITH, OR  
28 OTHERWISE SOLICIT, AN INDIVIDUAL WHO AT THE TIME IS A PROGRAM RECIPIENT  
29 BEFORE THE PROGRAM RECIPIENT ENROLLS IN THE MANAGED CARE  
30 ORGANIZATION UNLESS:

31 (I) AUTHORIZED BY THE DEPARTMENT; OR

32 (II) THE PROGRAM RECIPIENT INITIATES CONTACT.

1           **(O) (1) THE DEPARTMENT SHALL BE RESPONSIBLE FOR ENROLLING**  
2 **PROGRAM RECIPIENTS INTO MANAGED CARE ORGANIZATIONS.**

3           **(2) THE DEPARTMENT MAY CONTRACT WITH AN ENTITY TO PERFORM**  
4 **THE ENROLLMENT FUNCTION.**

5           **(3) THE DEPARTMENT OR ITS ENROLLMENT CONTRACTOR SHALL**  
6 **ADMINISTER A HEALTH RISK ASSESSMENT DEVELOPED BY THE DEPARTMENT TO**  
7 **ENSURE THAT INDIVIDUALS WHO NEED SPECIAL OR IMMEDIATE HEALTH CARE**  
8 **SERVICES WILL RECEIVE THE SERVICES ON A TIMELY BASIS.**

9           **(4) THE DEPARTMENT OR ITS ENROLLMENT CONTRACTOR:**

10           **(I) MAY ADMINISTER THE HEALTH RISK ASSESSMENT ONLY**  
11 **AFTER THE PROGRAM RECIPIENT HAS CHOSEN A MANAGED CARE ORGANIZATION;**  
12 **AND**

13           **(II) SHALL FORWARD THE RESULTS OF THE HEALTH RISK**  
14 **ASSESSMENT TO THE MANAGED CARE ORGANIZATION CHOSEN BY THE PROGRAM**  
15 **RECIPIENT WITHIN 5 BUSINESS DAYS.**

16           **(P) FOR A MANAGED CARE ORGANIZATION WITH WHICH THE SECRETARY**  
17 **CONTRACTS TO PROVIDE SERVICES TO PROGRAM RECIPIENTS UNDER THIS**  
18 **SECTION, THE SECRETARY SHALL ESTABLISH A MECHANISM TO INITIALLY ENSURE**  
19 **THAT EACH HISTORIC PROVIDER THAT MEETS THE DEPARTMENT'S QUALITY**  
20 **STANDARDS HAS THE OPPORTUNITY TO CONTINUE TO SERVE PROGRAM RECIPIENTS**  
21 **AS A SUBCONTRACTOR OF AT LEAST ONE MANAGED CARE ORGANIZATION.**

22           **(Q) (1) THE DEPARTMENT SHALL MAKE CAPITATION PAYMENTS TO EACH**  
23 **MANAGED CARE ORGANIZATION AS PROVIDED IN THIS SUBSECTION.**

24           **(2) IN CONSULTATION WITH THE INSURANCE COMMISSIONER, THE**  
25 **SECRETARY SHALL:**

26           **(I) SET CAPITATION PAYMENTS AT A LEVEL THAT IS**  
27 **ACTUARIALLY ADJUSTED TO THE BENEFITS PROVIDED; AND**

28           **(II) ACTUARIALLY ADJUST THE CAPITATION PAYMENTS TO**  
29 **REFLECT THE RELATIVE RISK ASSUMED BY THE MANAGED CARE ORGANIZATION.**

30           **(3) IN ACTUARIALLY ADJUSTING CAPITATION PAYMENTS UNDER**  
31 **PARAGRAPH (2)(II) OF THIS SUBSECTION, THE SECRETARY, IN CONSULTATION WITH**

1 THE INSURANCE COMMISSIONER, SHALL TAKE INTO ACCOUNT, TO THE EXTENT  
2 ALLOWED UNDER FEDERAL LAW, THE EXPENSES INCURRED BY THE MANAGED CARE  
3 ORGANIZATION APPLICABLE TO THE BUSINESS OF PROVIDING CARE TO ENROLLED  
4 INDIVIDUALS.

5 (R) (1) SCHOOL-BASED CLINICS AND MANAGED CARE ORGANIZATIONS  
6 SHALL COLLABORATE TO PROVIDE CONTINUITY OF CARE TO ENROLLEES.

7 (2) SCHOOL-BASED CLINICS SHALL BE DEFINED BY THE  
8 DEPARTMENT IN CONSULTATION WITH THE STATE DEPARTMENT OF EDUCATION.

9 (3) EACH MANAGED CARE ORGANIZATION SHALL REQUIRE A  
10 SCHOOL-BASED CLINIC TO PROVIDE TO THE MANAGED CARE ORGANIZATION  
11 INFORMATION, AS SPECIFIED BY THE DEPARTMENT, ABOUT AN ENCOUNTER WITH  
12 AN ENROLLEE OF THE MANAGED CARE ORGANIZATION BEFORE PAYING THE  
13 SCHOOL-BASED CLINIC.

14 (4) ON RECEIPT OF INFORMATION SPECIFIED BY THE DEPARTMENT,  
15 THE MANAGED CARE ORGANIZATION SHALL PAY, AT MEDICAID-ESTABLISHED  
16 RATES, SCHOOL-BASED CLINICS FOR COVERED SERVICES PROVIDED TO ENROLLEES  
17 OF THE MANAGED CARE ORGANIZATION.

18 (5) THE DEPARTMENT SHALL WORK WITH MANAGED CARE  
19 ORGANIZATIONS AND SCHOOL-BASED CLINICS TO DEVELOP COLLABORATION  
20 STANDARDS, GUIDELINES, AND A PROCESS TO ENSURE THAT THE SERVICES  
21 PROVIDED ARE COVERED AND MEDICALLY APPROPRIATE AND THAT THE PROCESS  
22 PROVIDES FOR TIMELY NOTIFICATION AMONG THE PARTIES.

23 (6) EACH MANAGED CARE ORGANIZATION SHALL MAINTAIN RECORDS  
24 OF ALL HEALTH CARE SERVICES:

25 (I) PROVIDED TO ITS ENROLLEES BY SCHOOL-BASED CLINICS;  
26 AND

27 (II) FOR WHICH THE MANAGED CARE ORGANIZATION HAS BEEN  
28 BILLED.

29 (S) THE DEPARTMENT SHALL ESTABLISH STANDARDS FOR THE TIMELY  
30 DELIVERY OF SERVICES TO ENROLLEES.

31 (T) (1) THE DEPARTMENT SHALL ESTABLISH A DELIVERY SYSTEM FOR  
32 SPECIALTY MENTAL HEALTH SERVICES FOR ENROLLEES OF MANAGED CARE  
33 ORGANIZATIONS.

1           **(2) THE BEHAVIORAL HEALTH ADMINISTRATION SHALL:**

2                   **(I) DESIGN AND MONITOR THE DELIVERY SYSTEM;**

3                   **(II) ESTABLISH PERFORMANCE STANDARDS FOR PROVIDERS IN**  
4 **THE DELIVERY SYSTEM; AND**

5                   **(III) ESTABLISH PROCEDURES TO ENSURE APPROPRIATE AND**  
6 **TIMELY REFERRALS FROM MANAGED CARE ORGANIZATIONS TO THE DELIVERY**  
7 **SYSTEM THAT INCLUDE:**

8                           **1. SPECIFICATION OF THE DIAGNOSES AND CONDITIONS**  
9 **ELIGIBLE FOR REFERRAL TO THE DELIVERY SYSTEM;**

10                           **2. TRAINING AND CLINICAL GUIDANCE IN APPROPRIATE**  
11 **USE OF THE DELIVERY SYSTEM FOR MANAGED CARE ORGANIZATION PRIMARY CARE**  
12 **PROVIDERS;**

13                           **3. PREAUTHORIZATION BY THE UTILIZATION REVIEW**  
14 **AGENT OF THE DELIVERY SYSTEM; AND**

15                           **4. PENALTIES FOR A PATTERN OF IMPROPER**  
16 **REFERRALS.**

17           **(3) THE DEPARTMENT SHALL COLLABORATE WITH MANAGED CARE**  
18 **ORGANIZATIONS TO DEVELOP STANDARDS AND GUIDELINES FOR THE PROVISION OF**  
19 **SPECIALTY MENTAL HEALTH SERVICES.**

20           **(4) THE DELIVERY SYSTEM SHALL:**

21                   **(I) PROVIDE ALL SPECIALTY MENTAL HEALTH SERVICES**  
22 **NEEDED BY ENROLLEES;**

23                   **(II) FOR ENROLLEES WHO ARE DUALY DIAGNOSED,**  
24 **COORDINATE THE PROVISION OF SUBSTANCE USE DISORDER TREATMENT SERVICES**  
25 **PROVIDED BY THE MANAGED CARE ORGANIZATIONS OF THE ENROLLEES;**

26                   **(III) CONSIST OF A NETWORK OF QUALIFIED MENTAL HEALTH**  
27 **PROFESSIONALS FROM ALL CORE DISCIPLINES;**

28                   **(IV) INCLUDE LINKAGES WITH OTHER PUBLIC SERVICE**  
29 **SYSTEMS; AND**

1 (V) COMPLY WITH QUALITY ASSURANCE, ENROLLEE INPUT,  
2 DATA COLLECTION, AND OTHER REQUIREMENTS SPECIFIED BY THE DEPARTMENT  
3 IN REGULATION.

4 (5) THE DEPARTMENT MAY CONTRACT WITH A MANAGED CARE  
5 ORGANIZATION FOR DELIVERY OF SPECIALTY MENTAL HEALTH SERVICES IF THE  
6 MANAGED CARE ORGANIZATION MEETS THE PERFORMANCE STANDARDS ADOPTED  
7 BY THE DEPARTMENT IN REGULATIONS.

8 (6) THE PROVISIONS OF § 15-1005 OF THE INSURANCE ARTICLE  
9 APPLY TO THE DELIVERY SYSTEM FOR SPECIALTY MENTAL HEALTH SERVICES  
10 ESTABLISHED UNDER THIS SUBSECTION AND ADMINISTERED BY AN  
11 ADMINISTRATIVE SERVICES ORGANIZATION.

12 (7) THE DEPARTMENT AND THE BEHAVIORAL HEALTH  
13 ADMINISTRATION SHALL ENSURE THAT THE DELIVERY SYSTEM HAS AN ADEQUATE  
14 NETWORK OF PROVIDERS AVAILABLE TO PROVIDE SUBSTANCE USE DISORDER  
15 TREATMENT FOR CHILDREN UNDER THE AGE OF 18 YEARS.

16 (U) THE DEPARTMENT SHALL INCLUDE A DEFINITION OF MEDICAL  
17 NECESSITY IN ITS QUALITY AND ACCESS STANDARDS.

18 (V) (1) THE DEPARTMENT SHALL ADOPT REGULATIONS RELATING TO  
19 ENROLLMENT, DISENROLLMENT, AND ENROLLEE APPEALS.

20 (2) PROGRAM RECIPIENTS SHALL HAVE THE RIGHT TO CHOOSE:

21 (I) THE MANAGED CARE ORGANIZATION WITH WHICH THEY  
22 ARE ENROLLED; AND

23 (II) THE PRIMARY CARE PROVIDER TO WHOM THEY ARE  
24 ASSIGNED WITHIN THE MANAGED CARE ORGANIZATION.

25 (3) IF A RECIPIENT IS DISENROLLED AND REENROLLS WITHIN 120  
26 DAYS AFTER THE RECIPIENT'S DISENROLLMENT, THE DEPARTMENT SHALL:

27 (I) ASSIGN THE RECIPIENT TO THE MANAGED CARE  
28 ORGANIZATION IN WHICH THE RECIPIENT PREVIOUSLY WAS ENROLLED; AND

29 (II) REQUIRE THE MANAGED CARE ORGANIZATION TO ASSIGN  
30 THE RECIPIENT TO THE PRIMARY CARE PROVIDER OF RECORD AT THE TIME OF THE  
31 RECIPIENT'S DISENROLLMENT.

1           **(4) WHENEVER A RECIPIENT HAS TO SELECT A NEW MANAGED CARE**  
2 **ORGANIZATION BECAUSE THE RECIPIENT'S MANAGED CARE ORGANIZATION HAS**  
3 **DEPARTED FROM THE PROGRAM ESTABLISHED UNDER SUBSECTION (A) OF THIS**  
4 **SECTION, THE DEPARTING MANAGED CARE ORGANIZATION:**

5           **(I) SHALL PROVIDE A WRITTEN NOTICE TO THE RECIPIENT 60**  
6 **DAYS BEFORE DEPARTING FROM THE PROGRAM ESTABLISHED UNDER SUBSECTION**  
7 **(A) OF THIS SECTION;**

8           **(II) SHALL INCLUDE IN THE NOTICE THE NAME AND PROVIDER**  
9 **NUMBER OF THE PRIMARY CARE PROVIDER ASSIGNED TO THE RECIPIENT AND THE**  
10 **TELEPHONE NUMBER OF THE ENROLLMENT BROKER; AND**

11           **(III) WITHIN 30 DAYS AFTER DEPARTING FROM THE PROGRAM,**  
12 **SHALL PROVIDE THE DEPARTMENT WITH A LIST OF ENROLLEES AND THE NAME OF**  
13 **EACH ENROLLEE'S PRIMARY CARE PROVIDER.**

14           **(5) ON RECEIVING THE LIST PROVIDED BY THE MANAGED CARE**  
15 **ORGANIZATION, THE DEPARTMENT SHALL PROVIDE THE LIST TO:**

16           **(I) THE ENROLLMENT BROKER TO ASSIST AND PROVIDE**  
17 **OUTREACH TO RECIPIENTS IN SELECTING A MANAGED CARE ORGANIZATION; AND**

18           **(II) THE REMAINING MANAGED CARE ORGANIZATIONS FOR THE**  
19 **PURPOSE OF LINKING RECIPIENTS WITH A PRIMARY CARE PROVIDER IN**  
20 **ACCORDANCE WITH FEDERAL LAW AND REGULATION.**

21           **(6) SUBJECT TO SUBSECTION (DD)(4) AND (5) OF THIS SECTION, AN**  
22 **ENROLLEE MAY DISENROLL FROM A MANAGED CARE ORGANIZATION:**

23           **(I) WITHOUT CAUSE IN THE MONTH FOLLOWING THE**  
24 **ANNIVERSARY DATE OF THE ENROLLEE'S ENROLLMENT; AND**

25           **(II) FOR CAUSE, AT ANY TIME AS DETERMINED BY THE**  
26 **SECRETARY.**

27           **(W) THE DEPARTMENT OR ITS SUBCONTRACTOR, TO THE EXTENT FEASIBLE**  
28 **IN ITS MARKETING OR ENROLLMENT PROGRAMS, SHALL HIRE INDIVIDUALS**  
29 **RECEIVING ASSISTANCE UNDER THE PROGRAM OF AID TO FAMILIES WITH**  
30 **DEPENDENT CHILDREN ESTABLISHED UNDER TITLE IV, PART A OF THE SOCIAL**  
31 **SECURITY ACT, OR THE SUCCESSOR TO THE PROGRAM.**

1           **(X) THE DEPARTMENT SHALL DISENROLL AN ENROLLEE WHO IS A CHILD IN**  
2 **STATE-SUPERVISED CARE IF THE CHILD IS TRANSFERRED TO AN AREA OUTSIDE THE**  
3 **TERRITORY OF THE MANAGED CARE ORGANIZATION.**

4           **(Y) THE SECRETARY SHALL ADOPT REGULATIONS TO CARRY OUT THIS**  
5 **SECTION.**

6           **(Z) A MANAGED CARE ORGANIZATION SHALL PROVIDE COVERAGE FOR**  
7 **HEARING LOSS SCREENINGS OF NEWBORNS PROVIDED BY A HOSPITAL BEFORE**  
8 **DISCHARGE.**

9           **(AA) (1) THE DEPARTMENT SHALL PROVIDE ENROLLEES AND HEALTH**  
10 **CARE PROVIDERS WITH AN ACCURATE DIRECTORY OR OTHER LISTING OF ALL**  
11 **AVAILABLE PROVIDERS:**

12                   **(I) IN WRITTEN FORM, MADE AVAILABLE ON REQUEST; AND**

13                   **(II) ON AN INTERNET DATABASE.**

14           **(2) THE DEPARTMENT SHALL UPDATE THE INTERNET DATABASE AT**  
15 **LEAST EVERY 30 DAYS.**

16           **(3) THE WRITTEN DIRECTORY SHALL INCLUDE A CONSPICUOUS**  
17 **REFERENCE TO THE INTERNET DATABASE.**

18           **(BB) A MANAGED CARE ORGANIZATION MAY NOT APPLY A PRIOR**  
19 **AUTHORIZATION REQUIREMENT FOR A PRESCRIPTION DRUG USED AS**  
20 **POSTEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV IF THE PRESCRIPTION**  
21 **DRUG IS PRESCRIBED FOR USE IN ACCORDANCE WITH CENTERS FOR DISEASE**  
22 **CONTROL AND PREVENTION GUIDELINES.**

23           **(CC) THE SECRETARY SHALL ADOPT REGULATIONS FOR PHARMACY**  
24 **BENEFITS MANAGERS THAT CONTRACT WITH MANAGED CARE ORGANIZATIONS THAT**  
25 **ESTABLISH REQUIREMENTS FOR CONDUCTING AUDITS OF PHARMACIES OR**  
26 **PHARMACISTS THAT ARE:**

27                   **(1) TO THE EXTENT PRACTICABLE, SUBSTANTIVELY SIMILAR TO THE**  
28 **AUDIT PROVISIONS UNDER § 15-1629 OF THE INSURANCE ARTICLE; AND**

29                   **(2) CONSISTENT WITH FEDERAL LAW.**

30           **(DD) (1) THE DEPARTMENT SHALL ESTABLISH MECHANISMS FOR:**

1                   **(I) IDENTIFYING A PROGRAM RECIPIENT'S PRIMARY CARE**  
2 **PROVIDER AT THE TIME OF ENROLLMENT INTO A MANAGED CARE PROGRAM; AND**

3                   **(II) MAINTAINING CONTINUITY OF CARE WITH THE PRIMARY**  
4 **CARE PROVIDER IF:**

5                   1.     **THE PROVIDER HAS A CONTRACT WITH A MANAGED**  
6 **CARE ORGANIZATION OR A CONTRACTED MEDICAL GROUP OF A MANAGED CARE**  
7 **ORGANIZATION TO PROVIDE PRIMARY CARE SERVICES; AND**

8                   2.     **THE RECIPIENT DESIRES TO CONTINUE CARE WITH**  
9 **THE PROVIDER.**

10                  **(2) IF A PROGRAM RECIPIENT ENROLLS IN A MANAGED CARE**  
11 **ORGANIZATION AND REQUESTS ASSIGNMENT TO A PARTICULAR PRIMARY CARE**  
12 **PROVIDER WHO HAS A CONTRACT WITH THE MANAGED CARE ORGANIZATION OR A**  
13 **CONTRACTED GROUP OF THE MANAGED CARE ORGANIZATION, THE MANAGED CARE**  
14 **ORGANIZATION SHALL ASSIGN THE RECIPIENT TO THE PRIMARY CARE PROVIDER.**

15                  **(3) (I) A PROGRAM RECIPIENT MAY REQUEST A CHANGE OF**  
16 **PRIMARY CARE PROVIDERS WITHIN THE SAME MANAGED CARE ORGANIZATION AT**  
17 **ANY TIME.**

18                  **(II) IF THE PRIMARY CARE PROVIDER HAS A CONTRACT WITH**  
19 **THE MANAGED CARE ORGANIZATION OR A CONTRACTED GROUP OF THE MANAGED**  
20 **CARE ORGANIZATION, THE MANAGED CARE ORGANIZATION SHALL HONOR A**  
21 **REQUEST MADE UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.**

22                  **(4) IN ACCORDANCE WITH THE FEDERAL HEALTH CARE FINANCING**  
23 **ADMINISTRATION'S GUIDELINES, A PROGRAM RECIPIENT MAY ELECT TO**  
24 **DISENROLL FROM A MANAGED CARE ORGANIZATION IF THE MANAGED CARE**  
25 **ORGANIZATION TERMINATES ITS CONTRACT WITH THE DEPARTMENT.**

26                  **(5) A PROGRAM RECIPIENT MAY DISENROLL FROM A MANAGED CARE**  
27 **ORGANIZATION TO MAINTAIN CONTINUITY OF CARE WITH A PRIMARY CARE**  
28 **PROVIDER IF:**

29                  **(I) THE CONTRACT BETWEEN THE PRIMARY CARE PROVIDER**  
30 **AND THE MANAGED CARE ORGANIZATION OR CONTRACTED GROUP OF THE**  
31 **MANAGED CARE ORGANIZATION TERMINATES BECAUSE:**

32                  1.     **THE MANAGED CARE ORGANIZATION OR**  
33 **CONTRACTED GROUP OF THE MANAGED CARE ORGANIZATION TERMINATES THE**

1 PROVIDER'S CONTRACT FOR A REASON OTHER THAN QUALITY OF CARE OR THE  
2 PROVIDER'S FAILURE TO COMPLY WITH CONTRACTUAL REQUIREMENTS RELATED  
3 TO QUALITY ASSURANCE ACTIVITIES;

4                   2. A. THE MANAGED CARE ORGANIZATION OR  
5 CONTRACTED GROUP OF THE MANAGED CARE ORGANIZATION REDUCES THE  
6 PRIMARY CARE PROVIDER'S CAPITATED OR APPLICABLE FEE FOR SERVICES RATES;

7                   B. THE REDUCTION IN RATES IS GREATER THAN THE  
8 ACTUAL CHANGE IN RATES OR CAPITATION PAID TO THE MANAGED CARE  
9 ORGANIZATION BY THE DEPARTMENT; AND

10                   C. THE PROVIDER AND THE MANAGED CARE  
11 ORGANIZATION OR CONTRACTED GROUP OF THE MANAGED CARE ORGANIZATION  
12 ARE UNABLE TO NEGOTIATE A MUTUALLY ACCEPTABLE RATE; OR

13                   3. THE PROVIDER CONTRACT BETWEEN THE PROVIDER  
14 AND THE MANAGED CARE ORGANIZATION IS TERMINATED BECAUSE THE MANAGED  
15 CARE ORGANIZATION IS ACQUIRED BY ANOTHER ENTITY; AND

16                   (ii) 1. THE PROGRAM RECIPIENT DESIRES TO CONTINUE TO  
17 RECEIVE CARE FROM THE PRIMARY CARE PROVIDER;

18                   2. THE PROVIDER CONTRACTS WITH AT LEAST ONE  
19 OTHER MANAGED CARE ORGANIZATION OR CONTRACTED GROUP OF A MANAGED  
20 CARE ORGANIZATION; AND

21                   3. THE ENROLLEE NOTIFIES THE DEPARTMENT OR THE  
22 DEPARTMENT'S DESIGNEE OF THE ENROLLEE'S INTENTION WITHIN 90 DAYS AFTER  
23 THE CONTRACT TERMINATION.

24                   (6) THE DEPARTMENT SHALL PROVIDE TIMELY NOTIFICATION TO  
25 THE AFFECTED MANAGED CARE ORGANIZATION OF AN ENROLLEE'S INTENTION TO  
26 DISENROLL UNDER THE PROVISIONS OF PARAGRAPH (5) OF THIS SUBSECTION.

27 REVISOR'S NOTE: This section formerly was § 15-103(b)(1) through (26) and (29)  
28 through (33) and (f) of this subtitle.

29 In subsection (b)(1)(ii), the phrase "at least" was added for clarity.

30 In subsection (c), the reference to the "Maryland Children's Health Program"  
31 was deleted and duplicative language for Maryland Children's Health  
32 Program has been added as § 15-306 of this title to reflect the organization of  
33 this title.

1 In subsection (i)(1)(xviii), the phrase “tab on the State–designated health  
2 information exchange website required under § 19–145.1(b)(2)(iv) of this  
3 article” was substituted for the former phrase “after the tab on the  
4 State–designated health information exchange website required under §  
5 19–145(b)(2)(iv) of this article is developed” to reflect that the tab has been  
6 developed and to correct an erroneous cross–reference.

7 In subsections (i)(3)(v)5 and (v)(4), the phrase “program established under  
8 subsection (a) of this section” was substituted for the former references to the  
9 “Maryland Medicaid Managed Care Program” and the “HealthChoice  
10 Program”, respectively, for consistency throughout this section.

11 In subsection (dd)(3)(ii), the phrase “made under subparagraph (i) of this  
12 paragraph” was added for clarity.

13 Throughout this section, the term “substance use disorder” is substituted for  
14 the former references to “substance abuse” and “alcohol and drug abuse” and  
15 “with substance use disorders” is substituted for the former reference to  
16 “substance abusing” to update terminology to that used currently in the  
17 behavioral health community.

18 The only other changes were in style.

19 **15–103.2.**

20 (A) IN THIS SECTION, “COMMITTEE” MEANS THE MARYLAND MEDICAID  
21 ADVISORY COMMITTEE.

22 (B) THE DEPARTMENT SHALL ESTABLISH THE MARYLAND MEDICAID  
23 ADVISORY COMMITTEE.

24 (C) (1) THE COMMITTEE SHALL BE COMPOSED OF NOT MORE THAN 25  
25 MEMBERS.

26 (2) THE MAJORITY OF THE MEMBERS OF THE COMMITTEE SHALL BE  
27 ENROLLEES OR ENROLLEE ADVOCATES.

28 (3) AT LEAST FIVE MEMBERS OF THE COMMITTEE SHALL BE  
29 ENROLLEES REPRESENTATIVE OF THE ENTIRE MEDICAID POPULATION.

30 (4) THE COMMITTEE MEMBERS SHALL INCLUDE:

31 (I) AT LEAST FIVE CURRENT OR FORMER ENROLLEES OR THE  
32 PARENTS OR GUARDIANS OF CURRENT OR FORMER ENROLLEES;

1                   **(II) PROVIDERS WHO ARE FAMILIAR WITH THE MEDICAL NEEDS**  
2 **OF LOW-INCOME POPULATION GROUPS, INCLUDING BOARD-CERTIFIED**  
3 **PHYSICIANS;**

4                   **(III) HOSPITAL REPRESENTATIVES;**

5                   **(IV) AT LEAST FIVE BUT NOT MORE THAN 10 ADVOCATES FOR**  
6 **THE MEDICAID POPULATION, INCLUDING REPRESENTATIVES OF SPECIAL NEEDS**  
7 **POPULATIONS, SUCH AS:**

8                   1.     **CHILDREN WITH SPECIAL NEEDS;**

9                   2.     **INDIVIDUALS WITH PHYSICAL DISABILITIES;**

10                  3.     **INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES;**

11                  4.     **INDIVIDUALS WITH MENTAL ILLNESS;**

12                  5.     **INDIVIDUALS WITH BRAIN INJURIES;**

13                  6.     **MEDICAID AND MEDICARE DUAL ELIGIBLES;**

14                  7.     **INDIVIDUALS WHO ARE HOMELESS OR HAVE**  
15 **EXPERIENCED HOMELESSNESS;**

16                  8.     **INDIVIDUALS ENROLLED IN HOME- AND**  
17 **COMMUNITY-BASED SERVICES WAIVERS;**

18                  9.     **ELDERLY INDIVIDUALS;**

19                  10.  **LOW-INCOME INDIVIDUALS AND INDIVIDUALS**  
20 **RECEIVING BENEFITS THROUGH THE TEMPORARY ASSISTANCE FOR NEEDY**  
21 **FAMILIES PROGRAM; AND**

22                  11.  **INDIVIDUALS RECEIVING SUBSTANCE USE**  
23 **TREATMENT SERVICES;**

24                   **(V) TWO MEMBERS OF THE SENATE FINANCE COMMITTEE,**  
25 **APPOINTED BY THE PRESIDENT OF THE SENATE; AND**

26                   **(VI) THREE MEMBERS OF THE HOUSE OF DELEGATES,**  
27 **APPOINTED BY THE SPEAKER OF THE HOUSE.**

1           **(5) A DESIGNEE OF EACH OF THE FOLLOWING SHALL SERVE AS AN EX**  
2 **OFFICIO MEMBER OF THE COMMITTEE:**

3                   **(I) THE SECRETARY OF HUMAN SERVICES;**

4                   **(II) THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH**  
5 **CARE COMMISSION; AND**

6                   **(III) THE MARYLAND ASSOCIATION OF COUNTY HEALTH**  
7 **OFFICERS.**

8           **(6) THE SECRETARY SHALL APPOINT NONVOTING MEMBERS FROM**  
9 **MANAGED CARE ORGANIZATIONS WHO MAY PARTICIPATE IN COMMITTEE**  
10 **MEETINGS, UNLESS THE COMMITTEE MEETS IN CLOSED SESSION AS PROVIDED IN §**  
11 **3-305 OF THE GENERAL PROVISIONS ARTICLE.**

12           **(7) (I) EXCEPT AS SPECIFIED IN PARAGRAPHS (4)(V) AND (VI) AND**  
13 **(5) OF THIS SUBSECTION, THE MEMBERS OF THE COMMITTEE SHALL BE APPOINTED**  
14 **BY THE SECRETARY AND SERVE FOR A 4-YEAR TERM.**

15                   **(II) IN MAKING APPOINTMENTS TO THE COMMITTEE, THE**  
16 **SECRETARY SHALL PROVIDE FOR CONTINUITY AND ROTATION.**

17                   **(III) IN APPOINTING CONSUMER MEMBERS TO THE COMMITTEE,**  
18 **THE SECRETARY SHALL SEEK RECOMMENDATIONS FROM:**

19                   1.   **THE STATE PROTECTION AND ADVOCACY SYSTEM**  
20 **ORGANIZATION;**

21                   2.   **THE STATEWIDE INDEPENDENT LIVING COUNCIL;**

22                   3.   **THE DEVELOPMENTAL DISABILITIES COUNCIL;**

23                   4.   **THE DEPARTMENT OF DISABILITIES;**

24                   5.   **THE DEPARTMENT OF AGING;**

25                   6.   **CONSUMER ADVOCACY ORGANIZATIONS; AND**

26                   7.   **THE PUBLIC.**

1           **(D) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A**  
2 **MEMBER OF THE COMMITTEE:**

3                   **(I) MAY NOT RECEIVE COMPENSATION; BUT**

4                   **(II) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER**  
5 **THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE**  
6 **BUDGET.**

7           **(2) A MEMBER OF THE COMMITTEE WHO IS AN ENROLLEE IS**  
8 **ENTITLED TO REIMBURSEMENT FOR:**

9                   **(I) EXPENSES FOR PERSONAL AND DEPENDENT CARE**  
10 **INCURRED DURING THE MEETING AND DURING TRAVEL TIME TO AND FROM THE**  
11 **MEETING;**

12                   **(II) EXPENSES FOR COGNITIVE SUPPORTS RELATED TO THE**  
13 **MEETING; AND**

14                   **(III) APPROPRIATE TRANSPORTATION TO AND FROM THE**  
15 **MEETING.**

16           **(3) ON REQUEST, THE DEPARTMENT SHALL PROVIDE FOR A**  
17 **DEDICATED DEPARTMENT STAFF PERSON:**

18                   **(I) TO REVIEW MEETING MATERIALS WITH ENROLLEE**  
19 **MEMBERS IN ADVANCE OF A MEETING BY TELEPHONE OR IN PERSON; AND**

20                   **(II) TO PROVIDE REFERRALS TO ADVOCACY ORGANIZATIONS.**

21           **(E) (1) THE SECRETARY SHALL APPOINT THE CHAIR OF THE**  
22 **COMMITTEE.**

23                   **(2) THE DEPARTMENT SHALL PROVIDE STAFF FOR THE COMMITTEE.**

24                   **(3) THE COMMITTEE SHALL DETERMINE THE TIMES AND PLACES OF**  
25 **ITS MEETINGS.**

26                   **(4) (I) THE CHAIR OF THE COMMITTEE AND THE STAFF FOR THE**  
27 **COMMITTEE SHALL PROVIDE THE AGENDA, MINUTES, AND ANY WRITTEN**  
28 **MATERIALS TO BE PRESENTED OR DISCUSSED AT A MEETING TO THE MEMBERS OF**  
29 **THE COMMITTEE AT LEAST 5 DAYS BEFORE THE MEETING.**

1                   **(II) THE AGENDA, MINUTES, AND WRITTEN MATERIALS SHALL**  
2 **BE PROVIDED TO MEMBERS OF THE COMMITTEE IN A MANNER AND FORMAT THAT**  
3 **REASONABLY ACCOMMODATES THE SPECIFIC NEEDS OF THE MEMBER.**

4           **(F) IN ADDITION TO ANY DUTIES IMPOSED BY FEDERAL LAW AND**  
5 **REGULATION, THE COMMITTEE SHALL:**

6                   **(1) ADVISE THE SECRETARY ON THE IMPLEMENTATION, OPERATION,**  
7 **AND EVALUATION OF MANAGED CARE PROGRAMS UNDER THIS SECTION;**

8                   **(2) REVIEW AND MAKE RECOMMENDATIONS ON THE REGULATIONS**  
9 **DEVELOPED TO IMPLEMENT MANAGED CARE PROGRAMS UNDER § 15–103.1 OF THIS**  
10 **SUBTITLE;**

11                   **(3) REVIEW AND MAKE RECOMMENDATIONS ON THE STANDARDS**  
12 **USED IN CONTRACTS BETWEEN THE DEPARTMENT AND MANAGED CARE**  
13 **ORGANIZATIONS;**

14                   **(4) REVIEW AND MAKE RECOMMENDATIONS ON THE DEPARTMENT’S**  
15 **OVERSIGHT OF QUALITY ASSURANCE STANDARDS;**

16                   **(5) REVIEW DATA COLLECTED BY THE DEPARTMENT FROM MANAGED**  
17 **CARE ORGANIZATIONS PARTICIPATING IN THE PROGRAM AND DATA COLLECTED BY**  
18 **THE MARYLAND HEALTH CARE COMMISSION;**

19                   **(6) PROMOTE THE DISSEMINATION OF MANAGED CARE**  
20 **ORGANIZATION PERFORMANCE INFORMATION, INCLUDING LOSS RATIOS, TO**  
21 **ENROLLEES IN A MANNER THAT FACILITATES QUALITY COMPARISONS AND USES**  
22 **LAYMAN’S LANGUAGE;**

23                   **(7) ASSIST THE DEPARTMENT IN EVALUATING THE ENROLLMENT**  
24 **PROCESS; AND**

25                   **(8) REVIEW REPORTS OF THE OMBUDSMEN.**

26           REVISOR’S NOTE: This section formerly was § 15–103(b)(27) of this subtitle.

27           Subsection (a) is new language added to state expressly that which only was  
28 implied in the former § 15–103(b)(27), that references to “the Committee” were  
29 references to the Maryland Medicaid Advisory Committee.

30           In subsection (c)(4)(iv)11, the term “substance use” is substituted for the  
31 former reference to “substance abuse” to update terminology to that used  
32 currently in the behavioral health community.

1 In subsection (c)(7)(i), the reference to paragraph (4)(v) and (vi) was  
2 substituted for the former reference to paragraph (4) for clarity.

3 The only other changes were in style.

4 15-103.5.

5 (b) (1) The Department shall pay all fines collected under [§ 15-103(b)(12)(v)]  
6 **§ 15-103.1(I)(3)(V)** of this subtitle and penalties collected under [§ 15-103.7(e)(2)(iv)] **§**  
7 **15-103.9(E)(2)(IV)** of this subtitle to the Comptroller of the State.

8 15-103.8.

9 (a) (2) Except as provided in [§ 15-103.8] **§ 15-103.10** of this subtitle, the  
10 Department is not required to adopt regulations under paragraph (1) of this subsection for  
11 any change that may be made through a process other than the regulatory process.

12 15-109.

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

16 (1) Family of 1 – \$2,500.

17 (2) Family of 2 – \$3,000.

18 (3) Family of 3 – \$3,500.

19 (4) Family of 4 – \$4,000.

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

22 15-148.

23 (a) Except for a drug or device for which the U.S. Food and Drug Administration  
24 has issued a black box warning, the Program [and the Maryland Children's Health  
25 Program] may not apply a prior authorization requirement for a contraceptive drug or  
26 device that is:

27 (1) (i) An intrauterine device; or

28 (ii) An implantable rod;

1 (2) Approved by the U.S. Food and Drug Administration; and

2 (3) Obtained under a prescription written by an authorized prescriber.

3 (b) The Program [and the Maryland Children's Health Program] shall provide  
4 coverage for a single dispensing to an enrollee of a supply of prescription contraceptives for  
5 a 12-month period.

6 15-152.

7 (a) The Program [and the Maryland Children's Health Program] shall provide  
8 coverage for services rendered to an enrollee by a licensed pharmacist acting within the  
9 pharmacist's lawful scope of practice to the same extent as services rendered by any other  
10 licensed health care provider.

11 (b) Reimbursement for services provided under subsection (a) of this section may  
12 not be conditioned on whether the licensed pharmacist is:

13 (1) Employed by a physician, pharmacy, or facility; or

14 (2) Acting under a physician's orders.

15 15-158.

16 The Program [and the Maryland Children's Health Program] may not require prior  
17 authorization for a transfer to a special pediatric hospital.

18 15-301.

19 (b) The Maryland Children's Health Program shall provide, subject to the  
20 limitations of the State budget and any other requirements imposed by the State and as  
21 permitted by federal law or waiver, comprehensive medical care and other health care  
22 services to an individual who:

23 (1) Does not qualify for coverage under [§ 15-103(a)(2)] **§ 15-103(B)** of  
24 this title; and

25 15-304.

26 (b) (2) In addition to the school-based outreach program established under  
27 subsection (a) of this section, the Department, in consultation with the Maryland Medicaid  
28 Advisory Committee established under [§ 15-103(b)] **§ 15-103.2** of this title, shall develop  
29 mechanisms for outreach for the program with a special emphasis on identifying children  
30 who may be eligible for program benefits under the Maryland Children's Health Program  
31 established under § 15-301 of this subtitle.

1 **15-305.**

2 (A) ON OR BEFORE JANUARY 1, 2025, SUBJECT TO THE LIMITATIONS OF  
3 THE STATE BUDGET AND AS PERMITTED BY FEDERAL LAW, THE DEPARTMENT:

4 (1) SHALL ESTABLISH AN EXPRESS LANE ELIGIBILITY PROGRAM TO  
5 ENROLL INDIVIDUALS IN THE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH  
6 PROGRAM BASED ON ELIGIBILITY FINDINGS BY THE SUPPLEMENTAL NUTRITION  
7 ASSISTANCE PROGRAM;

8 (2) MAY NOT CONSIDER ANY OTHER INCOME OR ELIGIBILITY  
9 REQUIREMENTS;

10 (3) TO THE EXTENT THAT A WAIVER IS NEEDED TO MAXIMIZE THE  
11 NUMBER OF STATE RESIDENTS WHO MAY QUALIFY FOR THE EXPRESS LANE  
12 ELIGIBILITY PROGRAM, SHALL APPLY TO THE CENTERS FOR MEDICARE AND  
13 MEDICAID SERVICES FOR ONE OR MORE WAIVERS UNDER § 1115 OF THE FEDERAL  
14 SOCIAL SECURITY ACT TO IMPLEMENT THE EXPRESS LANE ELIGIBILITY PROGRAM;  
15 AND

16 (4) SUBJECT TO SUBSECTION (B) OF THIS SECTION, SHALL MAKE ALL  
17 REASONABLE EFFORTS TO EXPEDITE ENROLLMENT OF ELIGIBLE INDIVIDUALS IN  
18 THE EXPRESS LANE ELIGIBILITY PROGRAM.

19 (B) THE DEPARTMENT MAY PROPOSE OR IMPLEMENT THE USE OF EXPRESS  
20 LANE ELIGIBILITY FOR RENEWALS BEFORE PROPOSING OR IMPLEMENTING THE  
21 USE OF EXPRESS LANE ELIGIBILITY FOR INITIAL ENROLLMENT.

22 REVISOR'S NOTE: This section repeats the provisions of § 15-103(a)(5) of this title,  
23 as it relates to the Maryland Children's Health Program, to reflect the  
24 organization of the title.

25 **15-306.**

26 SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND AS PERMITTED BY  
27 FEDERAL LAW OR WAIVER, THE MARYLAND CHILDREN'S HEALTH PROGRAM MAY  
28 PROVIDE GUARANTEED ELIGIBILITY FOR EACH ENROLLEE FOR UP TO 6 MONTHS  
29 UNLESS AN ENROLLEE OBTAINS HEALTH INSURANCE THROUGH ANOTHER SOURCE.

30 REVISOR'S NOTE: This section repeats the provisions of § 15-103(b)(3) of this title,  
31 as it relates to the Maryland Children's Health Program, to reflect the  
32 organization of the title.

33 **15-307.**

1 (A) EXCEPT FOR A DRUG OR DEVICE FOR WHICH THE U.S. FOOD AND DRUG  
2 ADMINISTRATION HAS ISSUED A BLACK BOX WARNING, THE MARYLAND  
3 CHILDREN'S HEALTH PROGRAM MAY NOT APPLY A PRIOR AUTHORIZATION  
4 REQUIREMENT FOR A CONTRACEPTIVE DRUG OR DEVICE THAT IS:

5 (1) (I) AN INTRAUTERINE DEVICE; OR

6 (II) AN IMPLANTABLE ROD;

7 (2) APPROVED BY THE U.S. FOOD AND DRUG ADMINISTRATION; AND

8 (3) OBTAINED UNDER A PRESCRIPTION WRITTEN BY AN AUTHORIZED  
9 PRESCRIBER.

10 (B) THE MARYLAND CHILDREN'S HEALTH PROGRAM SHALL PROVIDE  
11 COVERAGE FOR A SINGLE DISPENSING TO AN ENROLLEE OF A SUPPLY OF  
12 PRESCRIPTION CONTRACEPTIVES FOR A 12-MONTH PERIOD.

13 REVISOR'S NOTE: This section repeats the provisions of § 15-148 of this title, as it  
14 relates to the Maryland Children's Health Program, to reflect the organization  
15 of the title.

16 15-308.

17 (A) THE MARYLAND CHILDREN'S HEALTH PROGRAM SHALL PROVIDE  
18 COVERAGE FOR SERVICES RENDERED TO AN ENROLLEE BY A LICENSED  
19 PHARMACIST ACTING WITHIN THE PHARMACIST'S LAWFUL SCOPE OF PRACTICE TO  
20 THE SAME EXTENT AS SERVICES RENDERED BY ANY OTHER LICENSED HEALTH CARE  
21 PROVIDER.

22 (B) REIMBURSEMENT FOR SERVICES PROVIDED UNDER SUBSECTION (A) OF  
23 THIS SECTION MAY NOT BE CONDITIONED ON WHETHER THE LICENSED PHARMACIST  
24 IS:

25 (1) EMPLOYED BY A PHYSICIAN, PHARMACY, OR FACILITY; OR

26 (2) ACTING UNDER A PHYSICIAN'S ORDERS.

27 REVISOR'S NOTE: This section repeats the provisions of § 15-152 of this title, as it  
28 relates to the Maryland Children's Health Program, to reflect the organization  
29 of the title.

30 15-309.

1           **THE MARYLAND CHILDREN’S HEALTH PROGRAM MAY NOT REQUIRE PRIOR**  
2 **AUTHORIZATION FOR A TRANSFER TO A SPECIAL PEDIATRIC HOSPITAL.**

3           REVISOR’S NOTE: This section repeats the provisions of § 15–158 of this title, as it  
4                           relates to the Maryland Children’s Health Program, to reflect the organization  
5                           of the title.

6           SECTION 3. AND BE IT FURTHER ENACTED, That it is the intent of the General  
7 Assembly that, except as expressly provided in this Act, this Act shall be construed as a  
8 nonsubstantive revision and may not otherwise be construed to render any substantive  
9 change in the law of the State.

10          SECTION 4. AND BE IT FURTHER ENACTED, That the Revisor’s Notes contained  
11 in this Act are not law and may not be considered to have been enacted as part of this Act.

12          SECTION 5. AND BE IT FURTHER ENACTED, That the publisher of the  
13 Annotated Code of Maryland, in consultation with and subject to the approval of the  
14 Department of Legislative Services, shall correct, with no further action required by the  
15 General Assembly, cross–references and terminology rendered incorrect by this Act or by  
16 any other Act of the General Assembly of 2026 that affects provisions enacted by this Act.  
17 The publisher shall adequately describe any correction that is made in an editor’s note  
18 following the section affected.

19          SECTION 6. AND BE IT FURTHER ENACTED, That this Act shall take effect  
20 October 1, 2026.

Approved:

\_\_\_\_\_  
Governor.

\_\_\_\_\_  
Speaker of the House of Delegates.

\_\_\_\_\_  
President of the Senate.