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Legislative Document **No. 1487**

S.P. 552 In Senate, May 1, 2013

An Act To Implement Managed Care in the MaineCare Program

Reference to the Committee on Health and Human Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator KATZ of Kennebec.
Cosponsored by Senators: CAIN of Penobscot, CRAVEN of Androscoggin, HILL of York, WOODBURY of Cumberland, Representatives: CHASE of Wells, HARVELL of Farmington, KESCHL of Belgrade.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §3174-WW is enacted to read:

§3174-WW. Patient-centered MaineCare reform

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Managed care plan" means an entity that contracts to provide services through a health insurer, specialty plan, health maintenance organization authorized under Title 24-A or a provider service network authorized by the department to provide services in the MaineCare program.

B. "Managed care program" means the program of integrated managed care for all covered MaineCare services implemented in accordance with this section.

C. "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity or is an approved provider service network and is paid a prospective per member, per month payment by the department to provide services in the MaineCare program.

D. "Provider service network" means an entity the controlling interest of which is owned by a health care practitioner or health care facility or a group of health care practitioners or health care facilities. For the purposes of this paragraph, "health care practitioner" has the same meaning as in section 1711-C, subsection 1, paragraph F and "health care facility" means a health care facility as defined in section 1711-C, subsection 1, paragraph D, a controlling interest of which is owned by one or more licensed nursing facilities, assisted living facilities with 17 or more beds, home health agencies, hospice programs or agencies providing community care for the elderly.

E. "Region" means a geographical area of the State that is either a district as defined in section 411, subsection 5 or is a region as defined in rules adopted by the department.

F. "Specialty plan" means a managed care plan that serves MaineCare members who meet specified criteria based on age, medical condition or diagnosis.

2. Managed care program. The department shall implement a program of integrated managed care for all covered MaineCare services.

3. Managed care plans. The following provisions apply to managed care plans under the MaineCare program.

A. Services in the managed care program must be provided by managed care plans that are capable of coordinating and delivering all covered services to enrollees.

B. The department shall select managed care plans to participate in the managed care program using requests for proposals. The procurement method must give the department the most flexibility and broadest power to negotiate value and provide potential bidders the most flexibility to innovate.

C. The department shall consider quality factors in the selection of managed care plans, including:

(1) Accreditation by a nationally recognized accrediting body;

(2) Documented policies and procedures for preventing fraud and abuse;

(3) Experience in serving enrollees and achieving quality standards;

(4) Availability and accessibility of primary and specialty care physicians in the relevant network;

(5) Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and

(6) The existence of an established presence in the State, or a commitment to establish a presence in the State.

D. After negotiations are conducted, the department shall select the managed care plans that are determined to be responsive and provide the best value to the department. Preference must be given to plans that have signed contracts with primary and specialty care physicians in sufficient numbers to meet access standards established pursuant to subsection 5, paragraph B, subparagraph (3).

E. The department may enter into a contract with a managed care plan only if the contracted services are funded or will be funded by the biennial or supplemental budget of the State.

4. Selection of managed care plans. The following provisions apply to selection of managed care plans to provide services under the MaineCare program.

A. The department shall select managed care plans through a procurement process that complies with the requirements of this section. The department shall procure a minimum of 3 and a maximum of 4 managed care plans for medical and behavioral services. At least one of the managed care plans selected must be a provider service network, if at least one provider service network bids to participate and meets the minimum criteria for selection.

B. Participation in the managed care program by specialty plans is subject to the procurement requirements in this section. The enrollment of a specialty plan in a region may not exceed 5% of total enrollees in the region.

5. Plan accountability. The following provisions apply to managed care plans in order to impose standards for plan accountability.

A. The department shall establish a 5-year contract with each managed care plan selected through the procurement process described in this section. A plan contract may be renewed for an additional 2 years. The department may extend the term of a plan contract to cover any delays during the transition to a new plan.

B. The department shall establish contract requirements that are necessary for the operation of the managed care program. In addition to any other provisions the department may determine to be necessary, the contract must require:

(1) Compensation for physicians for coordination of care, management of chronic disease and avoidance of the need for more costly services;

(2) Compensation for hospitals that reflects mutually acceptable rates, methods and terms of payment and that is not lower than similar fee-for-service rates paid by the department;

(3) Access standards that are specific, population-based standards for the number, type and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. The standards must allow the managed care plans to limit the providers in their networks based on credentials, quality indicators and price;

(4) An accurate and complete electronic database, available on the publicly accessible website of the managed care plan, of contracted providers, including information about licensure or registration, locations and hours of operation and specialty credentials and other certifications that allows comparison of providers to network adequacy standards and that accepts and displays feedback from patients;

(5) A prescribed drug formulary or preferred drug list available on the publicly accessible website of the managed care plan in a manner that is accessible to and searchable by members and providers. The requirements must require the managed care plan to update the list within 24 hours after making a change and to ensure that the prior authorization process for prescribed drugs is readily accessible to providers, including posting appropriate contact information on the publicly accessible website and providing timely responses to providers;

(6) An encounter data system to collect, process, store and report on covered services provided to all MaineCare members enrolled in prepaid plans;

(7) Specific performance standards and benchmarks or timelines for improving performance over the term of the contract.

(a) A managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

(b) A managed care plan shall collect and report health plan employer data and information set measures as specified by the department. These measures must be published on the publicly accessible website of the managed care plan in a manner that allows members to reliably compare the performance of plans. The department shall use the measures as a tool to monitor plan performance.

(c) A managed care plan must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract with the department is executed;

(8) A managed care plan to establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum, a provider credentialing system and ongoing provider monitoring, procedures for reporting

instances of fraud and abuse and designation of a program integrity compliance officer;

(9) A managed care plan to establish an internal process for reviewing and responding to grievances from enrollees and submit quarterly reports including the number, description and outcome of grievances filed by enrollees. The grievance procedure must meet the requirements of the department;

(10) A managed care plan to comply with the requirements of the department for enrollment reduction and withdrawal and for reporting encounter data. Failure to meet the requirement of this subparagraph must result in penalties or termination of a regional contract; and

(11) A managed care plan and the plan's fiscal agent or intermediary to comply with the prompt payment requirements of Title 24-A.

6. Payments to managed care plans. The following provisions apply to payments to managed care plans by the department.

A. The department shall pay prepaid plans per member, per month payments negotiated pursuant to this section. Payments must be at risk-adjusted rates based on historical utilization and spending data, projected and adjusted to reflect the eligibility category, geographic area and clinical risk profile of the members. In negotiating rates with the plans, the department shall consider any adjustments necessary to encourage plans to use the most cost-effective treatments of chronic disease; and

B. Provider service networks may be prepaid plans and receive per member, per month payments. A fee-for-service option must be available to a provider service network for the first 2 years of its contract period. During this fee-for-service option period, if the provider service network exceeds per member, per month costs equivalent to those of the prepaid plans, risk-adjusted for similar members, during the contract period, the provider service network shall refund 1/2 of the per member, per month case management fee paid by the department to that provider service network during that same contract year.

7. Enrollment; choice counseling; eligibility. Except as otherwise provided by law, the following provisions apply to enrollment in and choice counseling and eligibility for managed care plans.

A. A MaineCare member must enroll in a managed care plan during an annual open enrollment period unless specifically exempted under this section. The member must be provided a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the member. A MaineCare member must be provided 30 days in which to make a choice of plans.

B. The department shall implement a choice counseling system to ensure that a MaineCare member has timely access to accurate information on the available managed care plans. The counseling system must include plan-to-plan comparative information on benefits, provider networks, drug formularies, quality measures and other data points as determined by the department. Choice counseling must be made available through face-to-face interaction, through the publicly accessible website of

the department, by telephone and in writing and through other forms of relevant media. Materials must be provided in a culturally appropriate manner, consistent with federal requirements. The department shall implement a competitive bidding process for procurement of choice counseling functions. The choice counseling system may not be administered by a managed care plan.

C. After a MaineCare member has enrolled in a managed care plan, the member must have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause or during the annual open enrollment period.

D. The department shall automatically enroll into a managed care plan those MaineCare members who do not choose a plan. Except as otherwise outlined in this section, the department may not engage in practices that are designed to favor one managed care plan over another.

E. A MaineCare member who has access to private health care coverage may not be enrolled in a managed care plan and must use MaineCare financial assistance to pay for the member's share of the cost in such coverage. The amount of financial assistance provided for the member may not exceed the amount of the MaineCare premium that would have been paid to a managed care plan for that member.

F. A MaineCare member who becomes ineligible for MaineCare may voluntarily pay the managed care plan a monthly premium equal to the current equivalent per member, per month rate, plus 2%, for up to 36 months to maintain the member's MaineCare managed care plan coverage. Members must be provided at least 60 days to select this option, and the managed care plan may not reject any members during this 60-day period. A member who is more than 45 days late in paying the monthly premium to the managed care plan is ineligible for coverage under this option.

8. Eligible populations. MaineCare members must receive covered services through the managed care program, except that the following MaineCare members may be enrolled in a mandatory capitated care management program:

A. Persons who are eligible for MaineCare and for coverage under the federal Medicare program;

B. Persons who are 65 years of age or older;

C. Persons who are 18 years of age or older and eligible for MaineCare due to a disability;

D. Persons who require residential nursing facility care;

E. Children with special needs and children who are eligible for assistance under the federal supplemental security income program in 42 United States Code, Sections 1381 to 1383f;

F. Members of an Indian tribe if the program is administered by a tribal health department or health clinic, as defined in section 411, subsection 13; and

G. Children receiving services in a prescribed pediatric extended care facility.

9. MaineCare benefits under managed care plans. The following provisions govern benefits under MaineCare managed care plans.

A. Managed care plans shall cover, at a minimum, Medicaid benefits applicable to the category of eligible members.

B. As approved by the department, managed care plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions and provide coverage for additional services. The department shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plan's enrollees and to verify actuarial equivalence.

C. A plan operating in the managed care program shall establish a program to encourage and reward healthy behaviors by MaineCare members. MaineCare members must have the opportunity to earn a maximum of $125 per year to defray other health-related expenses for such healthy behaviors. At a minimum, a plan shall establish a medically approved smoking cessation program, a medically directed weight-loss program and a medically approved alcohol or substance abuse recovery program. A plan shall identify members who smoke, are morbidly obese or are diagnosed as suffering from alcohol or substance abuse and shall establish written agreements with those members to participate in these programs.

Sec. 2. Stakeholder group. No later than October 1, 2013, the Department of Health and Human Services shall convene a patient-centered MaineCare reform stakeholder group to provide input on the implementation of the Maine Revised Statutes, Title 22, section 3174-WW. The department shall invite the participation of providers, patients, managed care providers and Legislators.

Sec. 3. Federal approval; contingent effective date. The Department of Health and Human Services shall seek approval from the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services of a Medicaid state plan amendment under the United States Social Security Act, Section 1932(a) to require MaineCare members with access to employer-sponsored health care coverage to enroll in that coverage and use MaineCare financial assistance to pay for the member's share of the cost for such coverage. The amount of financial assistance provided for each member may not exceed the amount of the MaineCare premium that would have been paid to a managed care plan for that member. The provisions of the Maine Revised Statutes, Title 22, section 3174-WW, subsection 7, paragraph E take effect upon notification from the Department of Health and Human Services to the Revisor of Statutes that approval under this section has been granted.

Sec. 4. Selection of managed care plans. The department shall issue a request for proposals no later than October 1, 2013 to select managed care plans pursuant to the Maine Revised Statutes, Title 22, section 3174-WW, subsection 4. By January 1, 2014, the department shall begin implementation of the statewide managed care program, with full implementation in all regions and all populations by July 1, 2014. Beginning July 1, 2015, at least 2 of the managed care plans must also include all long-term care and home-based and community-based services for those MaineCare populations eligible for those services.

Sec. 5. State plan amendment and waivers; contingent effective date. By November 1, 2013, the Department of Health and Human Services shall apply to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services for approval of a state plan amendment under the United States Social Security Act, Section 1932(a) to implement the provisions of this Act and for all necessary waivers. The provisions of this Act take effect upon notification from the Department of Health and Human Services to the Revisor of Statutes that all necessary approvals under this section have been granted.

SUMMARY

This bill establishes managed care in the MaineCare program. The bill includes requirements for managed care plans and for contracting by the Department of Health and Human Services for managed care services. The bill specifies how MaineCare members enroll in managed care plans. The bill requires the Department of Health and Human Services to apply for approval of a Medicaid state plan amendment to allow use of MaineCare funds to purchase available employer-sponsored health coverage and delays implementation of that provision until approval has been granted.