

MAINE STATE LEGISLATURE

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130th MAINE LEGISLATURE

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Legislative Document

No. 1701

H.P. 1264

House of Representatives, May 13, 2021

An Act To Establish a Managed Care Program for MaineCare Services

Received by the Clerk of the House on May 11, 2021. Referred to the Committee on Health and Human Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

A handwritten signature in cursive script that reads "R B. Hunt".

ROBERT B. HUNT
Clerk

Presented by Representative MILLETT of Waterford.

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

2 **Sec. 1. 22 MRSA §3174-FFF** is enacted to read:

3 **§3174-FFF. MaineCare reform**

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

6 A. "Managed care organization" means an entity that contracts with the department to
7 provide managed care in the MaineCare program through a health insurer or health
8 maintenance organization authorized under Title 24-A that bears full risk under a
9 capitated payment.

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

12 **2. Managed care program.** The department shall implement a managed care program
13 for all covered MaineCare services. The department has full authority to manage the
14 program except that the department may not change eligibility categories and income
15 thresholds as determined in this Title. The department shall include in the requests for
16 proposals and in the contract with each managed care organization the requirement that the
17 provision of services to members of the MaineCare program must be managed on a
18 phased-in schedule over 4 years as provided in this subsection.

19 A. The following MaineCare members must be enrolled within 2 years of the
20 implementation of a managed care program and in each year thereafter:

21 (1) Persons who are eligible for MaineCare under section 3174-G, subsection 1,
22 paragraphs A, E, F, G and H; and

23 (2) Children who are not disabled and who are eligible for MaineCare under
24 section 3174-G, subsection 1, paragraphs B and D.

25 B. All of the eligibility groups under section 3174-G, subsection 1 not included in
26 paragraph A must be enrolled in the managed care program after the 2nd year of
27 implementation but before the end of the 4th year on a schedule as required by the
28 department after the department has received approval from the federal Department of
29 Health and Human Services, Centers for Medicare and Medicaid Services and after the
30 department adopts rules.

31 C. A MaineCare member who is not enrolled under paragraph A or B may voluntarily
32 enroll in a managed care program that provides services in the region of the State in
33 which the member lives.

34 D. A MaineCare member may not be required to enroll in a managed care program
35 unless there are 3 managed care organizations that can each meet all the requirements
36 in this section.

37 **3. Managed care organization requirements.** The following requirements apply to
38 contracts with managed care organizations.

39 A. The department shall require services in the managed care program to be provided
40 by managed care organizations that are capable of coordinating and delivering all
41 covered MaineCare services, including, but not limited to, physical health services,
42 prescription services, dental services, long-term care supports and services provided

1 under waiver programs and behavioral health services, on a statewide basis to all
2 members.

3 B. The department shall select managed care organizations using requests for
4 proposals. The procurement method must give the department broad flexibility and
5 power to negotiate value and must provide potential bidders the broad flexibility to
6 innovate.

7 C. The department shall include quality factors in the selection of managed care
8 organizations, including, but not limited to:

9 (1) Accreditation by a nationally recognized accrediting body;

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

11 (3) Experience in serving members and achieving quality standards;

12 (4) Availability and accessibility of primary care and specialty care physicians in
13 a relevant network;

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

16 (6) Capability to address social determinants of health or connect to programs that
17 address education, food insecurity and housing instability; and

18 (7) An office or a commitment to establishing an office for the managed care
19 organization in the State.

20 D. After negotiations are conducted under paragraph B, the department shall select
21 managed care organizations that the department determines to be responsive, to have
22 signed contracts with providers of covered services in sufficient numbers to meet
23 access standards established in this section and by rule and to provide the best value to
24 the department.

25 E. The department shall use a procurement method that results in 3 managed care
26 organizations that the department authorizes to enroll MaineCare members upon
27 negotiation of rates consistent with this section and applicable requirements of the
28 federal Department of Health and Human Services, Centers for Medicare and Medicaid
29 Services.

30 F. All contracts with managed care organizations entered into under this section are
31 contingent upon the appropriation and allocation by the Legislature of sufficient
32 funding to pay for the managed care program.

33 G. All contracts with managed care organizations entered into under this section are
34 contingent upon the managed care organizations having signed provider contracts as
35 required in paragraph D.

36 H. All contracts with managed care organizations include the responsibility for all
37 administrative services for members enrolled in the managed care program, including,
38 but not limited to, claims processing, care and case management, grievances, appeals
39 and other necessary administrative services.

40 **4. Managed care organization accountability.** The following provisions apply to
41 managed care organizations in order to ensure standards for managed care organization
42 accountability.

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

6 B. The department shall establish contract requirements that are necessary for the
7 operation of the managed care program. Contract requirements must include the
8 following:

9 (1) Defined measures and goals for risk-adjusted health outcomes, quality of care,
10 patient satisfaction and cost. Each measure and goal must be subject to specific
11 accountability measures and include penalties;

12 (2) Access standards that are specific and that are population-based for the number,
13 type and regional distribution of providers in managed care organization networks
14 to ensure access to care for both adults and children. The access standards must
15 allow the managed care organizations to limit the providers in their networks based
16 on credentials, quality indicators and cost;

17 (3) Measures for satisfaction compiled from members and disenrollment surveys;

18 (4) An internal process for reviewing and responding to grievances from members
19 and for submitting quarterly reports including the number, description and outcome
20 of grievances filed by members. The grievance procedure must meet the
21 requirements of the department;

22 (5) Participation and coordination with departmental efforts in health care payment
23 reform, including value-based purchasing; quality improvement; delivery system
24 improvement; improvement in members' experience of care; and participation in
25 other departmental initiatives, including participation in the patient-centered
26 medical homes. The department may require the managed care organization to
27 participate in initiatives regarding compensation for providers for coordination of
28 care, management of chronic disease and avoidance of the need for more costly
29 services;

30 (6) The managed care organization shall maintain and submit encounter and claims
31 data for all services provided to members in a manner and format and in accordance
32 with a time schedule specified by the department. Claims data for each encounter
33 submitted under this subparagraph must include the amount paid by the managed
34 care organization to all providers of services attributable to the encounter;

35 (7) The managed care organization shall establish program integrity functions and
36 activities to reduce the incidence of fraud and abuse, including, at a minimum, a
37 provider credentialing system and ongoing provider monitoring, procedures for
38 reporting instances of fraud and abuse and designation of a program integrity
39 compliance officer;

40 (8) A managed care organization shall provide that the commissioner and the
41 medical director of the MaineCare program have the authority to override any
42 denial of care by the managed care organization on the basis of medical necessity;

43 (9) A managed care organization must be subject to financial consequences,
44 backed by a performance bond or similar guarantee, for failure to meet quality

1 standards, access standards, member satisfaction standards or other requirements
2 of law or rule or of the contract between the department and the managed care
3 organization;

4 (10) A managed care organization is subject to the jurisdiction and oversight of
5 the Department of Professional and Financial Regulation, Bureau of Insurance and
6 shall comply with provisions of Title 24-A, including chapter 56-A;

7 (11) A managed care organization when providing to members and prospective
8 members written communications, including, but not limited to, notices, decisions
9 and explanations of benefits, shall provide those communications in a manner that
10 is readable at or near a 6th-grade reading level and offer translated versions of
11 materials, as required by the department;

12 (12) A managed care organization may allow for cost sharing in accordance with
13 the provisions of 42 United States Code, Section 1396o; and

14 (13) A managed care organization shall provide a reasonable contribution to pay
15 for the funding of the program integrity compliance officer under subparagraph
16 (7).

17 **5. Payments to managed care organizations.** The department shall pay managed
18 care organizations on the basis of per member, per month payments negotiated pursuant to
19 this subsection. Payments must be at risk-adjusted rates based on historical utilization and
20 spending data, projected and adjusted to reflect the eligibility category, geographic area
21 and clinical risk profile of the members with the provision for subsequent adjustment based
22 on actual enrollments and encounter data when available. In negotiating rates with the
23 managed care organizations, the department shall consider any adjustments necessary to
24 encourage organizations to use the most cost-effective means of improving outcomes and
25 providing specialized management of particular subgroups of populations with complex or
26 high-cost needs.

27 **6. Rate setting.** The department must establish rates in the contracts that include the
28 following:

29 A. Rates that are actuarially sound, including utilization assumptions that are
30 consistent with industry and local standards. Rates must be adjusted for risk and
31 include a portion that is at risk if quality and outcome measures established in contracts
32 are not met, including value-based payments;

33 B. Appropriate rate floors for in-network primary care physicians and specialty care
34 physicians and pharmacy dispensing fees to ensure the achievement of goals; and

35 C. Rates for services in the remaining fee-for-service programs.

36 **7. Rulemaking.** The department shall adopt rules as necessary to implement this
37 section. Rules adopted pursuant to this subsection are major substantive rules as described
38 in Title 5, chapter 375, subchapter 2-A.

39 **Sec. 2. Selection of managed care organizations.** The Department of Health
40 and Human Services shall issue a request for proposals no later than January 1, 2022 to
41 select managed care organizations pursuant to the Maine Revised Statutes, Title 22, section
42 3174-FFF. No later than 2 years after the implementation of a managed care program, the
43 managed care organizations shall enroll the populations required in Title 22, section

1 3174-FFF, subsection 2, paragraph A. No later than 4 years after the implementation of
2 the program, the managed care organizations shall enroll all members eligible for
3 MaineCare services, including members receiving long-term care supports and services
4 and home-based and community-based services under a waiver.

5 **Sec. 3. State plan amendment and waivers; contingent effective date.** By
6 November 1, 2021, the Department of Health and Human Services shall apply to the federal
7 Department of Health and Human Services, Centers for Medicare and Medicaid Services
8 for approval of a state plan amendment under the United States Social Security Act, Section
9 1932(a) to implement the provisions of this Act and for all necessary waivers. The
10 provisions of this Act take effect upon notification from the Department of Health and
11 Human Services to the Revisor of Statutes that all necessary approvals under this section
12 have been granted.

13 **Sec. 4. Department of Health and Human Services to integrate benefits.**
14 The Department of Health and Human Services shall explore options to create a companion
15 Medicare equivalent by managed care organizations with contracts with the department
16 that will facilitate the integration of the Medicaid and Medicare benefits under a single
17 provider for those individuals eligible for both programs.

18 SUMMARY

19 This bill establishes a managed care program for all covered MaineCare services. It
20 requires the Department of Health and Human Services to issue a request for proposals for
21 3 managed care organizations that are able to operate the managed care program on a
22 statewide basis. Within 2 years of the implementation of a managed care program, the
23 Medicaid expansion population, those covered by the federal Children's Health Insurance
24 Program and members categorically eligible as Temporary Assistance for Needy Families
25 program recipients must be enrolled in managed care organizations. Within 4 years of
26 implementation, all eligible MaineCare members must be enrolled in managed care
27 programs. The bill establishes the requirements for contracts for managed care
28 organizations. It requires the Department of Health and Human Services to apply for any
29 state plan amendments or waivers required by November 1, 2021. It requires the
30 department to explore options to create a plan that integrates Medicaid and Medicare
31 benefits for individuals.