131st MAINE LEGISLATURE

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H.P. 848	House of Representatives, March 28, 2023

An Act to Establish a Managed Care Program for MaineCare Services

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

ROBERT B. HUNT
Clerk

Presented by Representative MILLETT of Waterford.
Cosponsored by Representative: STOVER of Boothbay.

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

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

§3174-KKK. MaineCare reform

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

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

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

C. "Social determinants of health" means the conditions in which individuals are born, grow, live, work and age, as well as the social structures and economic systems that shape these conditions, including the social environment, physical environment and health services that influence health outcomes.

2. Managed care program. The department shall implement a managed care program for categorically eligible recipients of the Temporary Assistance for Needy Families program and the children's health insurance program as defined in section 3174-X, subsection 1, paragraph A and members eligible for the MaineCare program pursuant to section 3174-G, subsection 1, paragraph H. The department has full authority to manage the program except that the department may not change eligibility categories and income thresholds as determined in this Title. The department shall include in the requests for proposals and in the contract with each managed care organization the requirement that the provision of services to members of the MaineCare program must be managed on a phased-in schedule over 4 years as provided in this subsection.

A. By July 1, 2025, categorically eligible recipients of the Temporary Assistance for Needy Families program and the children's health insurance program as defined in section 3174-X, subsection 1, paragraph A and members eligible for the MaineCare program pursuant to section 3174-G, subsection 1, paragraph H must be enrolled in the managed care program and capitation payments to managed care organizations must begin.

B. Categorically eligible recipients of the Temporary Assistance for Needy Families program and the children's health insurance program as defined in section 3174-X, subsection 1, paragraph A and members eligible for the MaineCare program pursuant to section 3174-G, subsection 1, paragraph H may not be required to enroll in the managed care program until the department identifies and enters into contracts with at least 3 managed care organizations that it determines capable of meeting all the requirements in this section.

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

A. The department shall require services in the managed care program to be provided by managed care organizations that are capable of coordinating and facilitating access to all covered MaineCare services, including, but not limited to, physical health

services, prescription services, dental services, services provided under waiver programs and behavioral health services, on a statewide basis to all MaineCare members.

The department shall pursue federal waivers as applicable and necessary to address social determinants of health under the MaineCare program.

B. The department shall select managed care organizations using requests for proposals. The department shall design the requests for proposals to ensure the selection of proposals that will improve MaineCare member outcomes, ensure access to all covered MaineCare services and support the improvement of social determinants of health.

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

(1) Accreditation by a nationally recognized accrediting body;

(2) Quality factors provided by a national organization that collects health care effectiveness data and information and sets measures and standards to ensure MaineCare members receive high-quality care;

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

(4) Experience in serving MaineCare members and achieving quality standards;

(5) Availability and accessibility of primary care and specialty care providers in a relevant network;

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

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

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

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

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

F. All contracts with managed care organizations entered into under this section include the responsibility for all administrative services for MaineCare members enrolled in the managed care program, including, but not limited to, claims processing, care and case management, grievances, appeals and other necessary administrative services.

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

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

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

(1) Defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction and cost;

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

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

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

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

(6) Requirements for maintaining and submitting encounter and claims data for all services provided to MaineCare members in a manner and format and in accordance with a time schedule specified by the department. Claims data for each encounter submitted under this subparagraph must include the amount paid by the managed care organization to all providers of services attributable to the encounter;

(7) Requirements that the managed care organization 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;

(8) An appeals process within the department to review and reverse any denial of care by the managed care organization on the basis of medical necessity in accordance with federal requirements;

(9) Financial consequences imposed by the department on the managed care organization for failure to meet requirements of law or rule or of the contract between the department and the managed care organization;

(10) Requirements that the managed care organization must be licensed by the Department of Professional and Financial Regulation, Bureau of Insurance and is subject to oversight by the bureau on matters of financial solvency;

(11) Providing written communications, including, but not limited to, notices, decisions and explanations of benefits, in a manner that is readable at or near a 6th-grade reading level and offering translated versions of communications, as required by the department;

(12) Cost sharing in accordance with the provisions of 42 United States Code, Section 1396o; and

(13) A reasonable contribution to pay for the funding of the program integrity compliance officer under subparagraph (7).

5. Payments to managed care organizations. The department shall pay managed care organizations on the basis of per MaineCare member, per month payments negotiated pursuant to this subsection. 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 MaineCare members with the provision for subsequent adjustment based on actual enrollments and encounter data when available. In negotiating rates with the managed care organizations, the department shall consider any adjustments necessary to encourage the managed care organizations to use the most cost-effective means of improving outcomes and providing specialized management of particular subgroups of populations with complex or high-cost needs.

6. Ratesetting. The department shall establish rates in the contracts in accordance with this section that include the following:

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

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

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

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

Sec. 2. Selection of managed care organizations. The Department of Health and Human Services shall issue a request for proposals no later than January 1, 2024 to select managed care organizations pursuant to the Maine Revised Statutes, Title 22, section 3174-KKK. No later than July 1, 2025, the managed care organizations shall enroll the populations required in Title 22, section 3174-KKK, subsection 2, paragraph A and capitation payments must begin. No later than July 1, 2027, the managed care organizations shall enroll all members eligible for MaineCare services, including members

receiving long-term care supports and services and home-based and community-based services under a waiver, and capitation payments must begin.

Sec. 3. State plan amendment and waivers. By January 1, 2024, 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 in accordance with the United States Social Security Act, Section 1932(a) and for all necessary waivers to implement the provisions of this Act and to maximize federal funding for programs addressing social determinants of health as defined in the Maine Revised Statutes, Title 22, section 3174-KKK, subsection 1, paragraph C.

Sec. 4. Department of Health and Human Services to integrate benefits. The Department of Health and Human Services shall explore options to create a companion Medicare equivalent to the managed care program, as defined in the Maine Revised Statutes, Title 22, section 3174-KKK, subsection 1, paragraph B, with contracts with the department that will facilitate the integration of the Medicaid and Medicare benefits under a single provider for those individuals eligible for both programs.

SUMMARY

This bill establishes a managed care program for all covered MaineCare services. It requires the Department of Health and Human Services to issue a request for proposals for at least 3 managed care organizations that are able to operate the managed care program on a statewide basis. By July 1, 2025, the Medicaid expansion population, those covered by the children's health insurance program and members categorically eligible for the Temporary Assistance for Needy Families program must be enrolled in the managed care program. By July 1, 2027, all eligible MaineCare members must be enrolled in the managed care program. The bill establishes the requirements for contracts for managed care organizations. It requires the Department of Health and Human Services to apply for any state plan amendments or waivers required by January 1, 2024. It requires the department to explore options to create a plan that integrates Medicaid and Medicare benefits for individuals into a managed care program.