APPENDIX 1

Legislative and Regulatory Changes In HealthChoice

In the years following its enactment of the program's enabling legislation, the Maryland General Assembly has continued to update the HealthChoice program through legislative action and oversight of the Department's regulatory functions. The following is a chronological list of program changes:

1998 Program Changes

- *MCHP.* Enabling legislation for the Maryland Children's Health Program (MCHP) authorized enrollment in HealthChoice of children under age 19 and pregnant women with income too high for Medicaid but not over 200 percent of the federal poverty line (FPL). Because this first phase of MCHP is a Medicaid expansion program, MCHP enrollees receive the same benefits provided to Medicaid-eligible children enrolled in HealthChoice.
- *Dental services.* Legislation enacted requiring a five-year Oral Health Care Program, and establishing specific utilization targets, to expand dental services under HealthChoice.
- *Substance abuse treatment.* Department promulgates regulations requiring MCOs to use standard assessment instruments (POSIT/ASI and ASAM) for comprehensive substance abuse assessments and placement appraisals. Use of standard instruments would improve the accuracy and appropriateness of enrollees' assessment results and treatment placements, and would facilitate monitoring of substance abuse identification and treatment referrals from plan to plan.
- *Therapy services carve-out.* As was noted above, regulatory changes occurred to give occupational therapy, physical therapy, speech therapy, and audiology services to limited self-referral status in July 1998, and then, as of November 1999, to carve out these services from the benefit package for which MCOs are responsible. As a result, children enrolled in HealthChoice can access these medically necessary services through any Medicaid provider, who then submits a fee-for-service claim to the Medicaid program for direct reimbursement.
- *Other changes.* Other program changes in 1998 concerned: MCO payments to FQHCs (legislation requiring the Department to enforce the FQHCs' "reasonable cost of services" rate); GME regulations (creating a mechanism outside of capitation rates for reimbursing graduate medical education costs); regulations requiring timely encounter data submission by MCOs (within 60 days of receipt from a provider); and legislation requiring MCOs to develop and submit comprehensive outreach plans for improving enrollees' access to health care services.

1999 Program Changes

- *Capitation payment rates.* In the first year, the State's implementation of the risk-adjusted payment system resulted in a higher level of payments to MCOs than originally anticipated. Therefore in FY1999 a freeze of intermin rates was coupled with a new process that was implemented for the period beginning in January 2001. Regulations effecting this change were granted emergency status by the Maryland General Assembly's Administrative, Executive, and Legislative Review (AELR) Committee, which required that a committee be established to address capitation rates issues for FY 2000. The Department shifted the program's future rate-setting schedule from a fiscal year to calendar year basis, and proposed new rates for the 14-month period beginning November 1, 1999.
- *Other changes.* The responsibility for obtaining stop-loss insurance for excess hospital inpatient costs was shifted to the MCOs, as the Department all but eliminated its role as a source from which MCOs could purchase such coverage. The Joint Chairmen's Report on the FY 2000 budget recognized the Department's efforts (including a two percent hospital rate discount for prompt payment) to encourage MCOs to provide working capital advances to hospitals, and urged the Department to continue such efforts.

2000 Program Changes

- *MCHP expansion.* The General Assembly passed legislation expanding MCHP eligibility to include children with family income up to 300 percent of the FPL and pregnant women with income up to 250 percent of the FPL. Pregnant women gaining MCHP eligibility under this legislation became eligible for enrollment in a HealthChoice MCO as part of the MCHP Medicaid expansion component. Children with family income over 200 but not more than 300 percent of the FPL became eligible for a new program component called MCHP Premium, implemented July 1, 2001. MCHP Premium enrollees are required to pay a flat rate premium, which is assessed on a per-family, not per-child, basis.

  MCHP Premium has two premium levels, based on family income. An eligible individual whose family income is above 200 but not more than 250 percent of the FPL pays an amount equal to 2 percent of the annual income of a family of two at 200 percent of the FPL; an individual with family income above 250, but not more than 300 percent of the FPL pays an amount equal to 2 percent of the annual income of a family of two at 250 percent of the FPL.

  MCHP Premium provides "private option" premium assistance to enable parents to secure private health insurance coverage for their eligible children under an employer-sponsored health benefits plan only. If qualifying employer-sponsored coverage is not available, an eligible child is enrolled in a HealthChoice MCO with access to the same benefits as Medicaid-eligible HealthChoice enrollees.

- *Other changes.* The General Assembly enacted legislation aimed at maintaining continuity of care by allowing enrollees to disenroll from their MCO if their assigned PCP leaves the MCO. Another law enacted during the 2000 legislative session expanded Maryland Insurance Administration (MIA) oversight of MCOs' downstream risk arrangements, and required MCOs to comply with National Association of Insurance Commissioners' risk-based capital standards.

2001 Program Changes

- *MCO and provider continuity.* The General Assembly addressed provider continuity again in 2001 with legislation requiring that an individual disenrolled from the program who then is re-enrolled within 120 days must be re-assigned to the same MCO and the same PCP. The legislation also requires an MCO withdrawing from the program to provide enrollees at least 30 days prior written notice. The MCO must also provide the Department with a list of reassigned enrollees and their PCPs
- *Provider directories - dissemination.* The General Assembly also passed legislation during the 2001 session requiring the Department to maintain a written directory and an electronic database, updated monthly, of all available providers participating in HealthChoice. Consistent with its pre-existing practice, the Department distributes the written version of the directory to new enrollees and on request. The Department implemented its electronic provider directory in June 2001. It allows the user to search for a PCP or other provider by name, provider type, location, or MCO. However there continue to be numerous problems with information posted on the Department's website, and the Department is actively working to clean up the information in the provider directory.
- *Newborn issues.* The Department has launched a number of new initiatives to address identified problem areas affecting newborns born to HealthChoice enrollee mothers. Each MCO was required to establish a newborn coordinator to facilitate access issues immediately following the birth, assignment of the PCP, billing issues for providers and the receipt of a MCO card for the newborn. An on-going newborn workgroup was established with MCOs, providers, advocates and the Department. [Shelby – please help here]
- *Other changes.* The 2001 General Assembly also acted: to require a study of fee-for-service rates adequacy and an annual rate-setting process to assure provider participation; to compel the submission of encounter data by MCOs that are leaving the program (to avoid negative financial impact on remaining MCOs); and requiring that fines collected from MCOs be deposited in a non-lapsing fund to be used as financial incentives to reward MCOs that meet or exceed performance targets.

Federal Changes

In addition to the legislative and regulatory changes at the State level, there have been changes at the federal level which affect HealthChoice. Welfare reform resulted in a decline in the number of adults served by HealthChoice.