# 132nd MAINE LEGISLATURE

## FIRST SPECIAL SESSION-2025

**Legislative Document** **No. 1878**

H.P. 1249 House of Representatives, May 5, 2025

**An Act to Establish a Managed Care Program for MaineCare Services**

Received by the Clerk of the House on May 1, 2025. Referred to the Committee on Health and Human Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

ROBERT B. HUNT
Clerk

Presented by Representative STOVER of Boothbay.
Cosponsored by Senator STEWART of Aroostook and
Representatives: BRENNAN of Portland, DUCHARME of Madison, GRAHAM of North Yarmouth, GRAMLICH of Old Orchard Beach, JAVNER of Chester, SHAGOURY of Hallowell, Senators: MOORE of Washington, RENY of Lincoln.

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

**Sec. 1. 22 MRSA §3188-A** is enacted to read:

**§3188-A. Department to establish managed care program for MaineCare services**

**1. Definitions.** For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Capitation payment" means a monthly payment, paid per enrollee, by the department to a managed care organization under contract with the department at a negotiated rate included in the contract.

B. "Children's health insurance program" has the same meaning as in section 3174-X, subsection 1, paragraph A.

C. "Managed care" means the provision of financing or delivery of health care services to a patient through:

(1) Arrangements with selected providers to furnish health care services; and

(2) Financial incentives for patients to use the participating providers pursuant to subparagraph (1) and procedures included in the managed care program.

D. "Managed care organization" or "MCO" means an entity that contracts with the department that manages and controls health care services covered under the MaineCare program, including a health insurer or a health maintenance organization, authorized to operate in this State and that bears the full risk in an agreement for a capitation payment.

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

F. "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.

G. "TANF" has the same meaning as in section 3762, subsection 1, paragraph E.

**2. Managed care program; administration.** The department shall develop a managed care program. The department shall contract with managed care organizations as provided under this section to deliver MaineCare services through the managed care program statewide. The department shall require that managed care organizations operating the managed care program pursuant to subsection 5 provide coverage for services, including, but not limited to, physical health, behavioral health, pharmacy and dental services. The department may require coverage of additional services if it chooses and shall pursue federal waivers as applicable and necessary to address social determinants of health under the MaineCare program. The department has full authority to manage the managed care program, except that the department may not change eligibility categories, including income thresholds, as provided in this section.

**3. Covered individuals.** The following categories of Medicaid enrollees must be enrolled in the managed care program established pursuant to this section according to the time frame established in subsection 9:

A. Individuals covered under the TANF program;

B. Individuals participating in the children's health insurance program;

C. Individuals enrolled in Medicaid who have not attained 65 years of age and have a family income up to 138% of the federal poverty level who are eligible for enrollment only under provisions of the federal Patient Protection and Affordable Care Act establishing Medicaid expansion; and

D. Individuals who are dually eligible for Medicaid and Medicare.

**4. Requests for proposals; selection.** The department shall issue a request for proposals to select 3 MCOs to operate the managed care program according to this subsection.

A. The department shall select MCOs 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, nonemergency medical transit services, services provided under waiver programs and behavioral health services on a statewide basis to all MaineCare members described in subsection 3.

B. The department shall design the requests for proposals to ensure the selection of MCOs most likely to improve MaineCare member outcomes, ensure access to all covered MaineCare services and support the mitigation of social determinants of health.

C. The department shall include in the request for proposals the requirement that a bidding MCO must be able to meet the time frames for implementation of the managed care program as established in subsection 9.

D. The department shall include in the request for proposals a copy of the initial rates established pursuant to subsection 7.

E. In developing the selection process, the department shall develop a set of factors that the department must consider during the selection process to ensure the quality of an MCO. The department shall consider at least the following factors with respect to an MCO:

(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 that MaineCare members receive high-quality care;

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

(4) Experience in serving Medicaid 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) Whether the MCO has an office, or a commitment to establishing an office, in this State.

F. The department may contract with a consultant to assist with the selection process.

**5. Contracts with selected managed care organizations.** The department shall establish a 5-year contract with each managed care organization selected through the selection process described in subsection 4. A managed care organization contract may be renewed in one-year increments for up to an additional 3 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. The department shall establish basic requirements concerning the content of contract terms. Contracts entered into by the department under this subsection must include terms that:

A. Authorize the managed care organization to enroll MaineCare members upon negotiation of rates consistent with subsection 7 and applicable requirements of the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services;

B. Include the negotiated capitation payment rates and any agreed upon fee-for-service rates;

C. Require that the managed care organization is responsible 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;

D. Require the managed care organization to complete enrollment consistent with the requirements of subsection 9;

E. Define measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction and cost;

F. Establish 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;

G. Establish measures for managed care program enrollee satisfaction developed from disenrollment surveys and other sources of feedback from MaineCare enrollees;

H. Establish 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;

I. Address 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 organizations 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;

J. Include 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 paragraph must include the amount paid by the managed care organization to all providers of services attributable to the encounter;

K. Require that the managed care organization establish managed care 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 managed care program integrity compliance officer;

L. Require the managed care organization to make a reasonable contribution to pay for the funding of the managed care program integrity compliance officer required under paragraph K;

M. Allow the department, through an appeal process developed by 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;

N. Establish and give notice of financial consequences the department may impose on the managed care organization for failure to meet requirements of law or rule or for breach of contract between the department and the managed care organization;

O. Require the managed care organization to be licensed by the Department of Professional and Financial Regulation, Bureau of Insurance and give notice that the MCO is subject to oversight by the Bureau of Insurance on matters of financial solvency;

P. Require the managed care organization to provide all written communications to managed care program enrollees, 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; and

Q. Require cost sharing in accordance with the provisions of 42 United States Code, Section 1396o.

**6. Payments to managed care organizations.** The department shall pay managed care organizations on the basis of per enrollee, per month payments negotiated pursuant to subsection 7. The department shall also establish rates for services in the remaining fee-for-service programs.

**7. Ratesetting; capitation payments.** The department shall establish rates for capitation payments to managed care organizations, to be included in the department's contract with the managed care organization, according to the following:

A. Rates must be adjusted for risk 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 in the managed care program and encounter data when available;

B. Rates must be actuarially sound, including utilization assumptions that are consistent with industry and local standards;

C. Rates must be designed as value-based payments such that a portion of the payment to the MCO may be withheld if quality and outcome measures established in the contract are not met; and

D. Rates must be designed with appropriate minimum rates for in-network primary care and specialty care providers and pharmacy dispensing fees to ensure the achievement of goals.

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 of managed care program enrollees with complex or high-cost needs.

**8. Regulation by Bureau of Insurance.** A managed care organization contracted with the department pursuant to this section is subject to regulations under Title 24-A related to financial solvency of health insurers or health maintenance organizations, as applicable to the composition of that MCO.

**9. Implementation; enrollment time frame.** MaineCare enrollees must be enrolled in the managed care program according to the following time frame.

A. MaineCare enrollees described in subsection 3, paragraphs A, B and C must be enrolled in the managed care program by February 1, 2029.

B. MaineCare enrollees described in subsection 3, paragraph D must be enrolled in the managed care program, operated by the same 3 managed care organizations under contract to provide services to the populations described in paragraph A, by July 1, 2030.

Capitation payments to the contracted managed care organizations must begin by February 1, 2029 or whenever enrollment under paragraph A begins, whichever occurs earlier.

**10. Implementation; waivers and state Medicaid plan amendments.** By April 1, 2026, the department shall submit all waivers and state Medicaid plan amendments to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services necessary to implement this section.

**11. Report.** By December 3, 2025, the department shall submit a report to the Legislature concerning the department's plans for completing the transition of services to the managed care program within the time frame established in subsection 9, including any anticipated need to amend existing state law to establish the managed care program and complete the transfer of services consistent with this section.

**12. Rulemaking.** The department shall adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection must include, but are not limited to:

A. The establishment of an appeal process by which the department may review and reverse any denial of care by the managed care organization on the basis of medical necessity in accordance with federal requirements; and

B. The establishment of penalties that may be enforced against a managed care organization for violating any law or rule.

Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

## SUMMARY

This bill establishes a managed care program for MaineCare services.

The bill requires the Department of Health and Human Services to issue a request for proposals to contract with 3 managed care organizations to provide MaineCare services. Managed care refers to a system of delivering services through arrangements with selected providers to furnish health care services and financial incentives for patients to use the participating providers and procedures included in the managed care program. The model also requires that the department reimburse the managed care organizations primarily using negotiated monthly rate per enrollee, rather than a fee-for-service model.

The bill establishes a number of requirements for developing the procurement process and essential contract terms. The bill establishes deadlines by which specific categories of eligible enrollees must be enrolled in the managed care program, beginning February 1, 2029. The department must submit a report to the Legislature by December 3, 2025 detailing its plan for implementing the program within the timeline established by this legislation. The bill also includes a deadline of April 1, 2026, by which time the department must submit all waivers and amendments for the state Medicaid plan that are necessary to implement this legislation. The department is authorized to adopt rules. Rules adopted are considered major substantive rules under the Maine Administrative Procedure Act.