Unofficial Copy **1996 Regular Session**
SB0750/527539/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL NO. 750
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 3, after "to" insert "provide guaranteed eligibility in the Maryland Medical Assistance Program for a certain period; authorizing the Department to"; in lines 4 and 5, strike "authorizing the Department to prohibit" and substitute "prohibiting, under certain circumstances,"; in line 6, after "recipients;" insert "establishing certain requirements for managed care organizations participating in the Program;"; in the same line, strike "authorizing" and substitute "requiring"; in the same line, strike "require" and substitute "assure that, under certain circumstances,"; in the same line, strike the second "to"; in line 7, after "recipients;" insert "prohibiting a managed care organization from denying or terminating participation on its provider panel under certain circumstances; authorizing the Department to take certain actions; requiring the Department to take certain actions, including making capitation payments in a certain manner; requiring school-based clinics to take certain actions and provide certain information; requiring a certain delivery system for certain mental health care; requiring the Health Resources Planning Commission, in consultation with the Department of Health and Mental Hygiene and the Health Services Cost Review Commission, to conduct a certain study; requiring the Health Resources Planning Commission to submit a certain report by a certain date; requiring the establishment of a Maryland Medicaid Advisory Committee and a Long-Term Managed Care Advisory Committee; requiring the Department to propose certain regulations and adopt certain regulations;".

AMENDMENT NO. 2

On page 2, after line 35 insert:

"(B) "ENROLLEE" MEANS A PROGRAM RECIPIENT WHO IS ENROLLED IN A MANAGED CARE ORGANIZATION.

(C) "EXCEPTIONAL NEEDS CARE COORDINATOR" MEANS A PERSON EMPLOYED BY THE MANAGED CARE ORGANIZATION TO ASSIST INDIVIDUALS IN

(Over)

SPECIAL NEEDS POPULATIONS TO ACCESS, COORDINATE, AND OBTAIN SERVICES THAT MEET THE INDIVIDUALS' NEEDS.";

in lines 36 and 38, strike "(b)" and "(c)", respectively, and substitute "(D)" and "(F)", respectively; after line 37, insert:

"(E) (1) "HISTORIC PROVIDER" MEANS A HEALTH CARE PROVIDER, AS DEFINED IN §19-1501 OF THIS ARTICLE, WHOSE PATIENT PROFILE HAS INCLUDED A SUBSTANTIAL NUMBER, AS IDENTIFIED BY THE DEPARTMENT IN REGULATION, OF PROGRAM RECIPIENTS FOR AT LEAST 5 YEARS.

(2) "HISTORIC PROVIDER" INCLUDES, TO THE EXTENT THAT THE PROVIDER'S PATIENT PROFILE MEETS THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, ACADEMIC HEALTH CENTERS, OUTPATIENT PROGRAMS OWNED OR CONTROLLED BY HOSPITALS, COMMUNITY HEALTH CENTERS, SCHOOL-BASED HEALTH CLINICS, LOCAL HEALTH DEPARTMENTS, AND PHARMACIES.";

in line 38, after "means" insert "AN ORGANIZATION OR PROGRAM WHOSE ENROLLMENT DOES NOT EXCEED THE FEDERAL LIMIT OF 75% MEDICAID AND MEDICARE ENROLLEES, UNLESS AND UNTIL THE 75% LIMIT IS REPEALED FROM FEDERAL LAW OR WAIVED BY THE HEALTH CARE FINANCING ADMINISTRATION, AND IS";

in line 39, after "organization;" insert "OR".

On page 3, in line 5, strike "; or" and substitute a period; and strike lines 6 through 8 in their entirety.

AMENDMENT NO. 3

On page 3, in line 3, strike "UNDER FEDERAL LAW OR WAIVER"; in the same line, strike "MEDICAID"; in line 4, strike "AND IS"; after line 8, insert:

"(G) "OMBUDSMAN PROGRAM" MEANS A PROGRAM THAT ASSISTS ENROLLEES IN RESOLVING DISPUTES WITH MANAGED CARE ORGANIZATIONS IN A TIMELY MANNER AND THAT IS RESPONSIBLE, AT A MINIMUM, FOR THE FOLLOWING FUNCTIONS:

(1) INVESTIGATING DISPUTES BETWEEN ENROLLEES AND MANAGED CARE ORGANIZATIONS REFERRED BY THE ENROLLEE HOTLINE;

(2) REPORTING TO THE DEPARTMENT:

(I) THE RESOLUTION OF ALL DISPUTES;

(II) A MANAGED CARE ORGANIZATION'S FAILURE TO MEET THE DEPARTMENT'S REQUIREMENTS; AND

(III) ANY OTHER INFORMATION SPECIFIED BY THE DEPARTMENT;

(3) EDUCATING ENROLLEES ABOUT:

(I) THE SERVICES PROVIDED BY THE ENROLLEE'S MANAGED CARE ORGANIZATION; AND

(II) THE ENROLLEE'S RIGHTS AND RESPONSIBILITIES IN RECEIVING SERVICES FROM THE MANAGED CARE ORGANIZATION; AND

(4) ADVOCATING ON BEHALF OF THE ENROLLEE BEFORE THE MANAGED CARE ORGANIZATION, INCLUDING ASSISTING THE ENROLLEE IN USING THE MANAGED CARE ORGANIZATION'S GRIEVANCE PROCESS.";

and in lines 9 and 10, strike "(d)" and "(e)", respectively, and substitute "(H)" and "(I)", respectively.

AMENDMENT NO. 4

On page 5, in line 26, strike "AND"; in line 28, strike the period and substitute "; AND"; after line 28 insert:

"(VIII) SHALL PROVIDE SERVICES IN ACCORDANCE WITH FUNDING RESTRICTIONS INCLUDED IN THE ANNUAL STATE BUDGET BILL.";

after line 33 insert:

"(2) THE DEPARTMENT MAY CONTRACT DIRECTLY WITH A MANAGED

CARE ORGANIZATION TO SERVE PROGRAM RECIPIENTS WITH SPECIAL NEEDS, AS DEFINED BY THE DEPARTMENT, PROVIDED THAT THE MANAGED CARE ORGANIZATION AGREES TO PROVIDE OR TO ARRANGE TO PROVIDE ALL OF THE SERVICES REQUIRED TO BE PROVIDED BY A MANAGED CARE ORGANIZATION.";

strike line 34 in its entirety and substitute:

"(3) IF A MANAGED CARE ORGANIZATION AGREES TO PARTICIPATE IN THE PROGRAM, THE MANAGED CARE ORGANIZATION SHALL:";

in line 36, after "Department" insert "AND WHICH, AT A MINIMUM:

1. COMPLIES WITH ANY HEALTH CARE QUALITY IMPROVEMENT SYSTEM DEVELOPED BY THE HEALTH CARE FINANCING ADMINISTRATION;

2. COMPLIES WITH THE QUALITY REQUIREMENTS OF APPLICABLE STATE LICENSURE LAWS AND REGULATIONS;

3. COMPLIES WITH PRACTICE GUIDELINES AND PROTOCOLS SPECIFIED BY THE DEPARTMENT;

4. PROVIDES FOR AN ENROLLEE GRIEVANCE SYSTEM, INCLUDING AN ENROLLEE HOTLINE;

5. PROVIDES FOR ENROLLEE AND PROVIDER SATISFACTION SURVEYS, TO BE TAKEN AT LEAST ANNUALLY;

6. PROVIDES FOR A CONSUMER ADVISORY BOARD TO RECEIVE REGULAR INPUT FROM ENROLLEES;

7. PROVIDES FOR AN ANNUAL CONSUMER ADVISORY BOARD REPORT TO BE SUBMITTED TO THE SECRETARY; AND

8. COMPLIES WITH SPECIFIC QUALITY, ACCESS, DATA, AND PERFORMANCE MEASUREMENTS ADOPTED BY THE DEPARTMENT FOR TREATING ENROLLEES WITH SPECIAL NEEDS";

in line 37, strike "Collect and submit" and substitute "TO ENABLE THE DEPARTMENT TO MONITOR COMPLIANCE AND PROGRESS OF THE PROGRAM AND TO PROVIDE MANAGED CARE ORGANIZATIONS WITH TIMELY FEEDBACK TO ASSIST THE MANAGED CARE ORGANIZATION IN PROVIDING MORE EFFICIENT AND COST-EFFECTIVE CARE, SUBMIT"; in line 37, after "Department" insert a colon; in the same line, strike "service-specific" and substitute:

"1. SERVICE-SPECIFIC";

in line 38, after the semicolon insert "AND

2. UTILIZATION AND OUTCOME REPORTS, SUCH AS THE HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS), AS DIRECTED BY THE DEPARTMENT;";

and in line 40, strike "Program recipients" and substitute "ENROLLEES".

AMENDMENT NO. 5

On page 6, strike lines 1 and 2 in their entirety and substitute:

"(IV) DEMONSTRATE ORGANIZATIONAL CAPACITY TO PROVIDE SPECIAL PROGRAMS, INCLUDING OUTREACH, CASE MANAGEMENT, AND HOME VISITING, TAILORED TO MEET THE INDIVIDUAL NEEDS OF ALL ENROLLEES;";

in lines 3, 7, and 15, in each instance, strike "Program recipients" and substitute "ENROLLEES"; after line 10 insert:

"(IX) SUBJECT TO PARAGRAPH (9) OF THIS SUBSECTION, PROVIDE DIAGNOSTIC, EMERGENCY, PREVENTIVE, AND RESTORATIVE DENTAL SERVICES FOR

CHILDREN AND FOR ADULTS;";

in lines 11 and 14, strike "(ix)" and "(x)", respectively, and substitute "(X)" and "(XI)", respectively; in line 11, after "accountable" insert "AND HOLD ITS SUBCONTRACTORS ACCOUNTABLE"; in lines 12 and 13, strike "a penalty up to and including revocation of its Medicaid managed care contract" and substitute "ONE OR MORE OF THE FOLLOWING PENALTIES:

1. FINES;

2. SUSPENSION OF FURTHER ENROLLMENTS;

3. WITHHOLDING OF ALL OR PART OF THE CAPITATION PAYMENT;

4. TERMINATION OF THE CONTRACT;

5. DISQUALIFICATION FROM FUTURE PARTICIPATION IN THE PROGRAM; AND

6. ANY OTHER PENALTIES THAT MAY BE IMPOSED BY THE DEPARTMENT";

in line 13, strike "and"; in line 17, strike the period and substitute a semicolon; after line 17 insert:

"(XII) PROVIDE OR ARRANGE TO PROVIDE THOSE MENTAL HEALTH SERVICES TRADITIONALLY DELIVERED BY PRIMARY CARE PROVIDERS;

(XIII) PROVIDE EXCEPTIONAL NEEDS CARE COORDINATORS TO ASSIST INDIVIDUALS IN SPECIAL NEEDS POPULATIONS, AS DEFINED BY THE DEPARTMENT;

(XIV) PROVIDE OR ARRANGE TO PROVIDE ALL MEDICAID-COVERED SERVICES REQUIRED TO COMPLY WITH STATE STATUTES AND REGULATIONS MANDATING HEALTH AND MENTAL HEALTH SERVICES FOR

CHILDREN IN STATE SUPERVISED CARE:

1. ACCORDING TO STANDARDS SET BY THE DEPARTMENT; AND

2. LOCALLY, TO THE EXTENT THE SERVICES ARE AVAILABLE LOCALLY;

(XV) MAKE AVAILABLE TO ITS ENROLLEES THE DEPARTMENT'S SUMMARY OF THE QUALITY ASSURANCE PROGRAM REQUIREMENTS;

(XVI) SUBMIT TO THE DEPARTMENT AGGREGATE INFORMATION FROM THE QUALITY ASSURANCE PROGRAM, INCLUDING COMPLAINTS AND RESOLUTIONS FROM THE GRIEVANCE SYSTEM AND HOTLINE, AND SATISFACTION SURVEYS;

(XVII) INITIALLY PROVIDE, AT A MINIMUM, THE SAME SERVICE LEVEL THAT WAS CONTRACTUALLY REQUIRED TO BE PROVIDED BY MANAGED CARE ORGANIZATIONS TO MEDICAID ENROLLEES AS OF JANUARY 1, 1996;

(XVIII) REIMBURSE FOR THE FOLLOWING HEALTH CARE SERVICES PROVIDED, WITHOUT PRIOR APPROVAL FROM THE MANAGED CARE ORGANIZATION, TO AN ENROLLEE IN A HOSPITAL EMERGENCY FACILITY:

1. HEALTH CARE SERVICES THAT MEET THE DEFINITION OF EMERGENCY SERVICES IN § 19-701 OF THIS ARTICLE;

2. MEDICAL SCREENING SERVICES RENDERED TO MEET THE REQUIREMENTS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT;

3. MEDICALLY NECESSARY SERVICES IF THE MANAGED CARE ORGANIZATION AUTHORIZED, REFERRED, OR OTHERWISE ALLOWED THE

ENROLLEE TO USE THE EMERGENCY FACILITY AND THE MEDICALLY NECESSARY SERVICES ARE RELATED TO THE CONDITION FOR WHICH THE ENROLLEE WAS ALLOWED TO USE THE EMERGENCY FACILITY; AND

4. MEDICALLY NECESSARY SERVICES THAT RELATE TO THE CONDITION PRESENTED AND THAT ARE PROVIDED TO THE ENROLLEE IF THE MANAGED CARE ORGANIZATION FAILS TO PROVIDE 24-HOUR ACCESS TO A PHYSICIAN AS REQUIRED IN THE DEPARTMENT'S REGULATIONS;

(XIX) MAINTAIN AS PART OF THE ENROLLEE'S MEDICAL RECORD THE FOLLOWING INFORMATION:

1. THE BASIC HEALTH RISK ASSESSMENT CONDUCTED ON ENROLLMENT;

2. ANY INFORMATION THE MANAGED CARE ORGANIZATION RECEIVES THAT RESULTS FROM AN ASSESSMENT OF THE ENROLLEE CONDUCTED FOR THE PURPOSE OF ANY EARLY INTERVENTION, EVALUATION, PLANNING, OR CASE MANAGEMENT PROGRAM;

3. INFORMATION FROM THE LOCAL DEPARTMENT OF SOCIAL SERVICES REGARDING ANY OTHER SERVICE OR BENEFIT THE ENROLLEE RECEIVES, INCLUDING ASSISTANCE OR BENEFITS UNDER ARTICLE 88A OF THE CODE; AND

4. ANY INFORMATION THE MANAGED CARE ORGANIZATION RECEIVES FROM A SCHOOL-BASED CLINIC, A CORE SERVICES AGENCY, A LOCAL HEALTH DEPARTMENT, OR ANY OTHER PERSON THAT HAS PROVIDED HEALTH SERVICES TO THE ENROLLEE; AND

(XX) UPON PROVISION OF INFORMATION SPECIFIED BY THE DEPARTMENT UNDER PARAGRAPH (13) OF THIS SUBSECTION, PAY SCHOOL-BASED CLINICS FOR SERVICES PROVIDED TO THE MANAGED CARE ORGANIZATION'S ENROLLEES.".

AMENDMENT NO. 6

On page 6, after line 17, insert:

"(4) A MANAGED CARE ORGANIZATION MAY NOT DENY AN APPLICATION FOR PARTICIPATION OR TERMINATE PARTICIPATION ON ITS PROVIDER PANEL SOLELY ON THE BASIS OF THE LICENSE, CERTIFICATION, OR OTHER AUTHORIZATION OF THE PROVIDER TO PROVIDE SERVICES IF THE MANAGED CARE ORGANIZATION PROVIDES SERVICES WITHIN THE PROVIDER'S LAWFUL SCOPE OF PRACTICE.".

AMENDMENT NO. 7

On page 6, after line 25 insert:

"(5) THE DEPARTMENT SHALL:

(I) MAINTAIN AN OMBUDSMAN PROGRAM AND A LOCALLY ACCESSIBLE ENROLLEE HOTLINE;

(II) PERFORM FOCUSED MEDICAL REVIEWS OF MANAGED CARE ORGANIZATIONS, INCLUDING REVIEWS OF SPECIAL POPULATIONS;

(III) ESTABLISH WITHIN THE DEPARTMENT A PROCESS FOR HANDLING PROVIDER COMPLAINTS ABOUT MANAGED CARE ORGANIZATIONS; AND

(IV) ADOPT REGULATIONS RELATING TO APPEALS BY MANAGED CARE ORGANIZATIONS OF PENALTIES IMPOSED BY THE DEPARTMENT, INCLUDING REGULATIONS PROVIDING FOR AN APPEAL TO THE OFFICE OF ADMINISTRATIVE HEARINGS.

(6) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (III) OF THIS PARAGRAPH, THE DEPARTMENT SHALL DELEGATE RESPONSIBILITY FOR MAINTAINING THE OMBUDSMAN PROGRAM FOR A COUNTY TO THAT COUNTY'S LOCAL HEALTH DEPARTMENT ON THE REQUEST OF THE LOCAL HEALTH

DEPARTMENT.

(II) A LOCAL HEALTH DEPARTMENT MAY NOT SUBCONTRACT THE OMBUDSMAN PROGRAM.

(III) BEFORE THE DEPARTMENT DELEGATES RESPONSIBILITY TO A LOCAL HEALTH DEPARTMENT TO MAINTAIN THE OMBUDSMAN PROGRAM FOR A COUNTY, A LOCAL HEALTH DEPARTMENT THAT IS ALSO A MEDICAID PROVIDER MUST RECEIVE THE APPROVAL OF THE SECRETARY AND THE LOCAL GOVERNING BODY.".

AMENDMENT NO. 8

On page 6, strike in their entirety lines 26 and 27, inclusive, and substitute:

"(7) A MANAGED CARE ORGANIZATION MAY NOT:

(I) WITHOUT AUTHORIZATION BY THE DEPARTMENT, ENROLL AN INDIVIDUAL WHO AT THE TIME IS A PROGRAM RECIPIENT; OR

(II) HAVE FACE-TO-FACE OR TELEPHONE CONTACT WITH AN INDIVIDUAL WHO AT THE TIME IS A PROGRAM RECIPIENT BEFORE THE PROGRAM RECIPIENT ENROLLS IN THE MANAGED CARE ORGANIZATION UNLESS:

1. AUTHORIZED BY THE DEPARTMENT; OR

2. THE PROGRAM RECIPIENT INITIATES CONTACT.

(8) THE DEPARTMENT SHALL ESTABLISH A HEALTH RISK ASSESSMENT TO BE ADMINISTERED AT THE TIME OF ENROLLMENT TO ASSURE THAT PERSONS IN NEED OF SPECIAL OR IMMEDIATE HEALTH CARE SERVICES WILL RECEIVE APPROPRIATE CARE ON A TIMELY BASIS.";

in lines 28 and 32, strike "(4)(i)" and "(5)", respectively, and substitute "(9)" and "(10)", respectively; after line 29 insert:

"(I) THE SECRETARY MAY EXCLUDE ALL DENTAL PROCEDURES AND SERVICES FROM ANY PROGRAM DEVELOPED UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(II) THE SECRETARY MAY ESTABLISH A DENTAL MANAGED CARE PROGRAM FOR ENROLLEES.";

strike in their entirety lines 30 and 31, inclusive, and substitute:

"(III) THE SECRETARY MAY ESTABLISH A MANAGED CARE PROGRAM FOR PARTICIPANTS IN THE "PACE" PROJECT.";

and in lines 34 and 35, strike "may require as a condition of that contract that the managed care [plan] ORGANIZATION include" and substitute "SHALL INITIALLY ESTABLISH A MECHANISM TO ASSURE THAT A HISTORIC PROVIDER THAT MEETS THE DEPARTMENT'S QUALITY STANDARDS HAS THE OPPORTUNITY TO CONTINUE TO SERVE PROGRAM RECIPIENTS AS A SUBCONTRACTOR OF AT LEAST ONE MANAGED CARE ORGANIZATION".

On page 7, strike beginning with "PROVIDERS" in line 6 down through "SECRETARY" in line 7.

AMENDMENT NO. 9

On page 7, after line 7 insert:

"(11) THE DEPARTMENT SHALL MAKE CAPITATION PAYMENTS THAT ARE ACTUARIALLY ADJUSTED TO:

(I) REFLECT THE RELATIVE RISK ASSUMED, AS DETERMINED BY THE DEPARTMENT; AND

(II) ENCOURAGE MANAGED CARE ORGANIZATIONS TO DEVELOP

EXPERTISE IN TREATING SPECIAL NEEDS POPULATIONS.

(12) (I) A MANAGED CARE ORGANIZATION SHALL REPORT ANNUALLY TO THE DEPARTMENT, AS THE DEPARTMENT PRESCRIBES, THE EXPENSE AND LOSS RATIOS INCURRED BY THE MANAGED CARE ORGANIZATION IN DELIVERING SERVICES TO ENROLLEES.

(II) FOR CALENDAR YEAR 1997, IF THE MANAGED CARE ORGANIZATION'S LOSS RATIO IS LESS THAN 80% OR ITS EXPENSE RATIO IS GREATER THAN 20%, THE DEPARTMENT SHALL ADJUST THE PAYMENTS MADE TO THE MANAGED CARE ORGANIZATION, UNLESS THE DEPARTMENT GRANTS A WAIVER FROM THESE REQUIREMENTS.

(III) FOR CALENDAR YEAR 1998 AND AFTER, IF THE MANAGED CARE ORGANIZATION'S LOSS RATIO IS LESS THAN 85% OR ITS EXPENSE RATIO IS GREATER THAN 15%, THE DEPARTMENT SHALL ADJUST THE PAYMENTS MADE TO THE MANAGED CARE ORGANIZATION, UNLESS THE DEPARTMENT GRANTS A WAIVER FROM THESE REQUIREMENTS.

(13) (I) SCHOOL-BASED CLINICS AND MANAGED CARE ORGANIZATIONS SHALL COLLABORATE TO PROVIDE CONTINUITY OF CARE TO ENROLLEES.

(II) SCHOOL-BASED CLINICS SHALL BE DEFINED BY THE DEPARTMENT IN CONSULTATION WITH THE STATE DEPARTMENT OF EDUCATION.

(III) A MANAGED CARE ORGANIZATION SHALL REQUIRE A SCHOOL-BASED CLINIC TO PROVIDE CERTAIN INFORMATION, AS SPECIFIED BY THE DEPARTMENT, ABOUT AN ENCOUNTER WITH AN ENROLLEE OF THE MANAGED CARE ORGANIZATION PRIOR TO PAYING THE SCHOOL-BASED CLINIC AT MEDICAID-ESTABLISHED RATES.

(IV) A MANAGED CARE ORGANIZATION SHALL MAINTAIN A RECORD OF ALL SERVICES FOR WHICH IT HAS BEEN BILLED THAT HAVE BEEN PROVIDED TO AN ENROLLEE BY A SCHOOL-BASED CLINIC.

(V) THE DEPARTMENT SHALL WORK WITH MANAGED CARE ORGANIZATIONS AND SCHOOL-BASED CLINICS TO DEVELOP COLLABORATION STANDARDS, GUIDELINES, AND A PROCESS TO ASSURE THAT THE SERVICES PROVIDED ARE COVERED AND MEDICALLY APPROPRIATE AND THAT THE PROCESS PROVIDES FOR TIMELY NOTIFICATION AMONG THE PARTIES.

(14) THE DEPARTMENT SHALL ESTABLISH STANDARDS FOR THE TIMELY DELIVERY OF SERVICES TO ENROLLEES.

(15) THE DEPARTMENT SHALL ESTABLISH A DELIVERY SYSTEM FOR SPECIALITY MENTAL HEALTH CARE THAT SHALL:

(I) BE DESIGNED AND MONITORED BY THE MENTAL HYGIENE ADMINISTRATION, WHICH SHALL ESTABLISH THE PERFORMANCE STANDARDS FOR PROVIDERS IN THE DELIVERY SYSTEM;

(II) BE RESPONSIBLE FOR PROVIDING ALL SPECIALITY MENTAL HEALTH SERVICES NEEDED BY ENROLLEES WHOSE MENTAL ILLNESS REQUIRES SPECIALITY CARE;

(III) OFFER A BENEFIT PACKAGE THAT IS DESIGNED TO MEET THE NEEDS OF ENROLLEES DESCRIBED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH;

(IV) HAVE LINKAGES WITH OTHER PUBLIC SERVICE SYSTEMS;

(V) INCLUDE MANAGED CARE ORGANIZATIONS THAT ARE COST-EFFECTIVE AND THAT ENTER INTO AGREEMENTS WITH THE DEPARTMENT TO COMPLY WITH THE PERFORMANCE STANDARDS FOR PROVIDERS IN THE DELIVERY SYSTEM FOR SPECIALITY MENTAL HEALTH SERVICES; AND

(VI) COMPLY WITH THE QUALITY ASSURANCE, ENROLLEE INPUT, DATA COLLECTION, AND OTHER REQUIREMENTS SPECIFIED BY THE DEPARTMENT

IN REGULATION.

(16) THE DEPARTMENT SHALL INCLUDE A DEFINITION OF MEDICAL NECESSITY IN ITS QUALITY AND ACCESS STANDARDS.

(17) (I) THE DEPARTMENT SHALL ADOPT REGULATIONS RELATING TO ENROLLMENT, DISENROLLMENT, AND ENROLLEE APPEALS.

(II) THE REGULATIONS SHALL PERMIT AN ENROLLEE TO DISENROLL WITHOUT CAUSE FROM A MANAGED CARE ORGANIZATION IN THE MONTH FOLLOWING THE ANNIVERSARY DATE OF THE ENROLLEE'S ENROLLMENT.

(III) AN ENROLLEE MAY DISENROLL FROM A MANAGED CARE ORGANIZATION FOR CAUSE.

(18) THE DEPARTMENT OR ITS SUBCONTRACTOR, TO THE EXTENT FEASIBLE IN ITS MARKETING PROGRAM, SHALL HIRE INDIVIDUALS RECEIVING ASSISTANCE UNDER THE PROGRAM OF AID TO FAMILIES WITH DEPENDENT CHILDREN ESTABLISHED UNDER TITLE IV, PART A, OF THE SOCIAL SECURITY ACT.

(19) THE SECRETARY SHALL ADOPT REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SECTION.".

AMENDMENT NO. 10

On page 7, before line 8 insert:

"(20) (I) THE DEPARTMENT SHALL ESTABLISH THE MARYLAND MEDICAID ADVISORY COMMITTEE, COMPOSED OF NO MORE THAN 25 MEMBERS, THE MAJORITY OF WHOM ARE ENROLLEES OR ENROLLEE ADVOCATES.

(II) THE COMMITTEE MEMBERS SHALL INCLUDE:

1. CURRENT OR FORMER ENROLLEES OR THE PARENTS OR GUARDIANS OF CURRENT OR FORMER ENROLLEES;

2. PROVIDERS WHO ARE FAMILIAR WITH THE MEDICAL NEEDS OF LOW-INCOME POPULATION GROUPS, INCLUDING BOARD-CERTIFIED PHYSICIANS;

3. HOSPITAL REPRESENTATIVES;

4. ADVOCATES FOR THE MEDICAID POPULATION, INCLUDING REPRESENTATIVES OF SPECIAL NEEDS POPULATIONS;

5. THREE MEMBERS OF THE FINANCE COMMITTEE OF THE SENATE OF MARYLAND, APPOINTED BY THE PRESIDENT OF THE SENATE; AND

6. THREE MEMBERS OF THE ENVIRONMENTAL MATTERS COMMITTEE OF THE MARYLAND HOUSE OF DELEGATES, APPOINTED BY THE SPEAKER OF THE HOUSE.

(III) A DESIGNEE OF EACH OF THE FOLLOWING SHALL SERVE AS AN EX-OFFICIO MEMBER OF THE COMMITTEE:

1. THE SECRETARY OF HUMAN RESOURCES;

2. THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION; AND

3. THE MARYLAND ASSOCIATION OF COUNTY HEALTH OFFICERS.

(IV) IN ADDITION TO ANY DUTIES IMPOSED BY FEDERAL LAW AND REGULATION, THE COMMITTEE SHALL:

1. ADVISE THE SECRETARY ON THE IMPLEMENTATION, OPERATION, AND EVALUATION OF MANAGED CARE PROGRAMS UNDER THIS

SECTION;

2. REVIEW AND MAKE RECOMMENDATIONS ON THE REGULATIONS DEVELOPED TO IMPLEMENT MANAGED CARE PROGRAMS UNDER THIS SECTION;

3. REVIEW AND MAKE RECOMMENDATIONS ON THE STANDARDS USED IN CONTRACTS BETWEEN THE DEPARTMENT AND MANAGED CARE ORGANIZATIONS;

4. REVIEW AND MAKE RECOMMENDATIONS ON THE DEPARTMENT'S OVERSIGHT OF QUALITY ASSURANCE STANDARDS;

5. REVIEW DATA COLLECTED BY THE DEPARTMENT FROM MANAGED CARE ORGANIZATIONS PARTICIPATING IN THE PROGRAM AND DATA COLLECTED BY THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION;

6. PROMOTE THE DISSEMINATION OF MANAGED CARE ORGANIZATION PERFORMANCE INFORMATION, INCLUDING LOSS RATIOS, TO ENROLLEES IN A MANNER THAT FACILITATES QUALITY COMPARISONS AND USES LAYMAN'S LANGUAGE;

7. ASSIST THE DEPARTMENT IN EVALUATING THE ENROLLMENT PROCESS;

8. REVIEW REPORTS OF THE OMBUDSMEN; AND

9. PUBLISH AND SUBMIT AN ANNUAL REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1312 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY.

(V) EXCEPT AS SPECIFIED IN SUBPARAGRAPHS (II) AND (III) OF THIS PARAGRAPH, THE MEMBERS OF THE MARYLAND MEDICAID ADVISORY COMMITTEE SHALL BE APPOINTED BY THE SECRETARY AND SERVE FOR A 4-YEAR

TERM.

(VI) IN MAKING APPOINTMENTS TO THE COMMITTEE, THE SECRETARY SHALL PROVIDE FOR CONTINUITY AND ROTATION.

(VII) THE SECRETARY SHALL APPOINT THE CHAIRMAN OF THE COMMITTEE.

(VIII) THE SECRETARY SHALL APPOINT NON-VOTING MEMBERS FROM MANAGED CARE ORGANIZATIONS WHO MAY PARTICIPATE IN COMMITTEE MEETINGS, UNLESS THE COMMITTEE MEETS IN CLOSED SESSION AS PROVIDED IN § 10-508 OF THE STATE GOVERNMENT ARTICLE.

(IX) THE COMMITTEE SHALL DETERMINE THE TIMES AND PLACES OF ITS MEETINGS.

(X) A MEMBER OF THE COMMITTEE:

1. MAY NOT RECEIVE COMPENSATION; BUT

2. IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.";

and in line 24, strike "(d)" and substitute "(F)".

AMENDMENT NO. 11

On page 8, in line 24, after the period insert "Public testimony shall be permitted following the Secretary's mandatory managed care program quarterly reports."; in line 29, strike "and"; in line 31, after "recipients" insert ", and the Department's plan to incorporate competitive bidding"; after line 36 insert:

"SECTION 4. AND BE IT FURTHER ENACTED, That the Secretary shall apply for a waiver from the Health Care Financing Administration or take such other steps as are necessary to

enroll a managed care organization whose Medicaid and Medicare enrollment exceeds 75% of the organization's total enrollment or will exceed 75% of its total enrollment.

SECTION 5. AND BE IT FURTHER ENACTED, That managed care organizations participating in the Maryland Medical Assistance Program shall reimburse hospitals in accordance with rates established by the Health Services Cost Review Commission.

SECTION 6. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene and the Maryland Insurance Administration shall propose regulations establishing solvency requirements for Medicaid managed care organizations no later than July 1, 1996.

SECTION 7. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene and the Maryland Insurance Administration shall establish an approval process that takes no longer than 60 days for organizations applying to be Medicaid managed care organizations. The standards and requirements for Medicaid managed care organization applications shall be available to the public no later than 60 days before the program takes effect.

SECTION 8. AND BE IT FURTHER ENACTED, That:

(a) The Health Resources Planning Commission, in consultation with the Department of Health and Mental Hygiene and the Health Services Cost Review Commission, shall study the existing impact on existing community health centers and other primary care providers of the laws, regulations, the grant of a federal waiver, and other governmental actions that authorize or require the enrollment of Maryland Medical Assistance Program recipients into managed care plans or organizations.

(b) The study shall include:

(1) an assessment of the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured, and the ability of education programs in primary care specialties, including medical residences, to provide clinical training sites; and

(2) an examination of the utilization and reimbursement levels between

managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care.

(c) On or before November 1, 1996, the Health Resources Planning Commission shall submit a report on the results of its investigation and study, together with any resulting policy recommendations, to the Governor, the Secretary of Health and Mental Hygiene, and, subject to § 2-1312 of the State Government Article, the General Assembly.".

AMENDMENT NO. 12

On page 8, before line 37 insert:

"SECTION 9. AND BE IT FURTHER ENACTED, That:

(a) (1) The Secretary of Health and Mental Hygiene shall establish a Long-Term Managed Care Advisory Committee, composed of no more than 15 members and including legislators, consumers, health care providers, advocates, and State and local agency representatives, to advise on development of a managed care proposal for the Medicaid long-term care population.

(2) The Committee shall hear public testimony and conduct public meetings in each region of the State concerning managed care issues for the continuum of long-term health care services.

(3) By November 1, 1996, the Committee shall issue a report to the Secretary with findings and recommendations addressing, at a minimum:

(i) the population to be served;

(ii) the types of services to be provided;

(iii) the mechanisms for providing services;

(iv) funding; and

(v) implementation issues.

(4) By January 1, 1997, the Secretary shall develop and present to the Governor, and subject to § 2-1312 of the State Government Article, the General Assembly a managed care proposal for the Medicaid long-term care population.

(b) (1) Additionally, the Secretary may appoint a Long-Term Managed Care Technical Advisory Group, composed of individuals with technical, as well as programmatic, expertise to develop managed care pilot programs.

(2) The pilot programs, in selected regions of the State, may:

(i) encourage Medicaid recipients to join managed care plans for long-term care benefits coverage;

(ii) blend, to the extent possible, Medicaid and Medicare funds for managed care;

(iii) utilize varying eligibility criteria, in light of the continued expansion of the long-term care population; and

(iv) utilize innovative methods of long-range financing.

(3) Any data and information generated by these pilot programs shall be reviewed by the Long-Term Managed Care Advisory Committee and used in the design of managed care programs for the long-term care population.

SECTION 10. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene is authorized to make prepaid payments to a program that provided services to individuals under: Title 7, Subtitle 3; Title 7, Subtitle 7; § 8-204; Title 8, Subtitle 4; Title 10, Subtitle 9; or Title 10, Subtitle 12 of the Health-General Article.

SECTION 11. AND BE IT FURTHER ENACTED, That this Act may not be construed to supersede the authority of a local county school board, or in Baltimore City the Mayor and City

Council, in consultation with parents of students in the school district and parents of students attending a school in which a school-based clinic is based, to initiate, discontinue, or manage the operations of a school-based clinic in the school district.";

and in line 37, strike "4." and substitute "12.".