BY: Finance Committee

AMENDMENTS TO HOUSE BILL NO. 1051
(Third Reading File Bill)

AMENDMENT NO. 1

On pages 1 and 2, strike beginning with "authorizing" in line 3 on page 1 down through "Program." in line 7 on page 2, inclusive, and substitute "authorizing the Department to provide guaranteed eligibility in the Maryland Medical Assistance Program for a certain period; prohibiting, under certain circumstances, managed care organizations from enrolling Program recipients; establishing certain requirements for managed care organizations participating in the Program; requiring the Department to assure that, under certain circumstances, managed care organizations include providers who have historically served Program recipients; 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; defining certain terms; and generally relating to eligibility and managed care organizations under the Maryland Medical Assistance Program.".

AMENDMENT NO. 2

On page 2, strike in their entirety lines 8 through 17, inclusive; and strike in their entirety lines 24 through 28, inclusive.

AMENDMENT NO. 3

On page 3, strike beginning with "and" in line 14 down through "Administration" in line 15.

(Over)

AMENDMENT NO. 4

On pages 3 through 9, strike in their entirety the lines beginning with line 35 on page 3 through line 36 on page 9, inclusive.

AMENDMENT NO. 5

On pages 10 through 25, strike in their entirety the lines beginning with line 1 on page 10 through line 21 on page 25, inclusive, and substitute:

"Article - Health - General

15-101.

(a) In this title the following words have the meanings indicated.

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

[(b)] (D) "Facility" means a hospital or nursing facility including an intermediate care facility, skilled nursing facility, comprehensive care facility, or extended care facility.

(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.

[(c)] (F) "Managed care [plan] ORGANIZATION" means 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:

(1) A certified health maintenance organization; OR

(2) A managed care system that is not a health maintenance organization and does not hold a certificate of authority to operate as an insurer but is authorized to receive prepaid capitation payments subject to the regulatory solvency requirements, appropriate for the risk to be assumed, adopted by the Insurance Commissioner in consultation with the Secretary[; or].

[(3) A program that provides 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 this article.]

(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;

(Over)

(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.

[(d)] (H) "Program" means the Maryland Medical Assistance Program.

[(e)] (I) "Program recipient" means an individual who receives benefits under the Program.

15-102.

(a) Subject to the limitations of the State budget [and the availability of federal funds], the Department shall provide preventive and home care services for indigent and medically indigent individuals.

15-102.1.

(a) The General Assembly finds that it is a goal of this State to promote the development of a health care system that provides adequate and appropriate health care SERVICES to indigent and medically indigent individuals.

(b) The Department shall, to the extent permitted, subject to the limitations of the State budget [and the availability of federal funds]:

(1) Provide a comprehensive system of quality health care SERVICES with an emphasis on prevention, education, individualized care, and appropriate case management;

(2) Develop a prenatal care program for Program recipients and encourage its utilization;

(3) Allocate State resources for the Program to provide a balanced system of health care SERVICES to the population served by the Program;

(4) Seek to coordinate the Program activities with other State programs and initiatives that are necessary to address the health care needs of the population served by the Program;

(5) Promote Program policies that facilitate access to and continuity of care by encouraging:

(i) Provider availability throughout the State;

(ii) Consumer education;

(iii) The development of ongoing relationships between Program recipients and primary health care providers; and

(iv) The regular review of the Program's regulations to determine whether the administrative requirements of those regulations are unnecessarily burdensome on Program providers;

(6) Strongly urge health care providers to participate in the Program and thereby address the needs of Program recipients;

(7) Require health care providers who participate in the Program to provide access to Program recipients on a nondiscriminatory basis in accordance with State and federal law;

(8) Seek to provide appropriate levels of reimbursement for providers to encourage greater participation by providers in the Program;

(Over)

(9) Promote individual responsibility for maintaining good health habits;

(10) Encourage the Program and Maryland's Health Care Regulatory System to work to cooperatively promote the development of an appropriate mix of health care providers, limit cost increases for the delivery of health care to Program recipients, and insure the delivery of quality health care to Program recipients;

(11) Encourage the development and utilization of cost-effective and preventive alternatives to the delivery of health care services to appropriate Program recipients in inpatient institutional settings;

(12) Encourage the appropriate executive agencies to coordinate the eligibility determination, policy, operations, and compliance components of the Program;

(13) Work with representatives of inpatient institutions, third party payors, and the appropriate State agencies to contain Program costs;

(14) Identify and seek to develop an optimal mix of State, federal, and privately financed health care services for Program recipients, within available resources through cooperative interagency efforts;

(15) Develop joint legislative and executive branch strategies to persuade the federal government to reconsider those policies that discourage the delivery of cost effective health care SERVICES to Program recipients;

(16) Evaluate departmental recommendations as to those persons whose financial need or health care needs are most acute;

(17) Establish mechanisms for aggressively pursuing recoveries against third parties permitted under current law and exploring additional methods for seeking to recover other moneys expended by the Program; and

(18) Take appropriate measures to assure the quality of health care SERVICES

provided by managed care [plans] ORGANIZATIONS.

15-103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(2) The Program:

(i) Subject to the limitations of the State budget [and the availability of federal funds], shall provide comprehensive medical and other health care SERVICES for indigent individuals or medically indigent individuals or both;

(ii) Shall provide, subject to the limitations of the State budget [and the availability of federal funds], comprehensive medical and other health care SERVICES for all QUALIFYING pregnant women and, at a minimum, all children currently under the age of 1 whose family income falls below 185 percent of the poverty level, as permitted by the federal law;

(iii) Shall provide, subject to the limitations of the State budget, family planning [service] SERVICES to women currently eligible for comprehensive medical care and other health care under item (ii) of this paragraph for 5 years after the second month following the month in which the woman delivers her child;

(iv) Shall provide, subject to the limitations of the State budget [and the availability of federal funds], comprehensive medical and other health care SERVICES for all children from the age of 1 year up through and including the age of 5 years whose family income falls below 133 percent of the poverty level, as permitted by the federal law;

(v) Shall provide, subject to the limitations of the State budget [and the availability of federal funds], comprehensive medical care and other health care SERVICES for all children born after September 30, 1983 who are at least 6 years of age but are under 19 years of age whose family income falls below 100 percent of the poverty level, as permitted by federal law; [and]

(VI) MAY PROVIDE, SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND AS PERMITTED BY FEDERAL LAW OR WAIVER, GUARANTEED

ELIGIBILITY FOR A PERIOD NOT TO EXCEED 6 MONTHS;

[(vi)] (VII) May include bedside nursing care for eligible Program recipients.; AND

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

(3) Subject to restrictions in federal law or waivers, the Department may impose cost-sharing on Program recipients.

(b) (1) [The] AS PERMITTED BY FEDERAL LAW OR WAIVER, THE Secretary may establish a program under which Program recipients are required to enroll in managed care [plans] ORGANIZATIONS.

(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.

[(2) A managed care plan shall:]

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

(i) Have a quality assurance program in effect which is subject to the approval of the Department 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;

(ii) [Collect and submit] 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 to the Department: [service-specific]

1. SERVICE-SPECIFIC data by service type in a format to be established by the Department; AND

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

(Over)

(iii) Promote timely access to and continuity of health care SERVICES for [Program recipients] ENROLLEES;

[(iv) Develop special programs tailored to meet the individual health care needs of Program recipients;]

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

(v) Provide assistance to [Program recipients] ENROLLEES in securing necessary health care services;

(vi) Provide or assure alcohol and drug abuse treatment for substance abusing pregnant women;

(vii) Educate [Program recipients] ENROLLEES on health care prevention and good health habits;

(viii) Assure necessary provider capacity in all geographic areas under contract;

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

[(ix)] (X) Be accountable AND HOLD ITS SUBCONTRACTORS ACCOUNTABLE for standards established by the Department and, upon failure to meet those standards, be subject to [a penalty up to and including revocation of its Medicaid managed care contract] 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; [and]

[(x)] (XI) Subject to applicable federal and State law, include incentives for [Program recipients] ENROLLEES to comply with provisions of the managed care [plan] ORGANIZATION[, and disincentives for failing to comply with provisions of the managed care plan.];

(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.

(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.

[(3) The Secretary shall ensure participation in the development of the managed care program by the involvement of a broad-based steering committee including legislative, consumer, and provider representation.

(4) The Secretary shall submit to the Senate Finance Committee and House Environmental Matters Committee of the General Assembly for their review any proposals developed under paragraph (1) of this subsection prior to requesting approval by the U.S. Department of Health and Human Services under § 1115 of the Social Security Act.]

(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.

(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.

[(5) (i)] (9) The Secretary may exclude specific populations or services from any program developed under paragraph (1) of this subsection.

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

(Over)

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

[(ii) The Secretary may establish a managed care program for any population or service excluded under subparagraph (i) of this paragraph.]

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

[(6)] (10) For a managed care [plan] ORGANIZATION with which the Secretary contracts to provide services to Program recipients under this subsection, the Secretary [may require as a condition of that contract that the managed care plan include] 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[, to the extent economically feasible, particular providers in providing those services in the following circumstances:

(i) In areas that have been served historically by a community health center, the Secretary may require a managed care plan to include that community health center in its delivery of service to Program recipients who have traditionally obtained health care services through that community health center;

(ii) For providers with residency programs for the training of health care professionals, the Secretary may require a managed care plan to include those providers in its delivery of service to Program recipients; and

(iii) In other circumstances to meet particular needs of Program recipients or the community being served as provided in regulations adopted by the Secretary].

(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.

(Over)

(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 SPECIALTY 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 SPECIALTY MENTAL HEALTH SERVICES NEEDED BY ENROLLEES WHOSE MENTAL ILLNESS REQUIRES SPECIALTY 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 SPECIALTY 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.

(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

(Over)

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 SUBPARAGRAPH (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 NONVOTING 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.".

AMENDMENT NO. 6

On page 26, in line 2, strike "(d)" and substitute "(F)"; and strike in their entirety lines 9 and 10, inclusive.

AMENDMENT NO. 7

On pages 26 through 28, strike in their entirety the lines beginning with line 35 on page 26 through line 12 on page 28, inclusive, and substitute:

"SECTION 2. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall appear before the Senate Finance Committee and House Environmental Matters

Committee of the General Assembly to report on the implementation of the Secretary's mandatory managed care program on a quarterly basis until 2 years after the Program is first implemented. Public testimony shall be permitted following the Secretary's mandatory managed care program quarterly reports. No later than 1 year after the implementation date of the program, the Secretary shall submit a written report to the Committees which shall include information about the number of Program recipients enrolled in managed care organizations, the quality assurance programs for the managed care organizations, a comprehensive financial assessment of the management of care of Program recipients in the organizations, the scope of Program benefits, the availability of special programs tailored to meet the individual health care needs of Program recipients, and the Department's plan to incorporate competitive bidding.

SECTION 3. AND BE IT FURTHER ENACTED, That no later than 15 days prior to submitting any proposed regulations implementing the Secretary's mandatory managed care program to the AELR Committee for review, the Secretary shall submit the proposed regulations to the Senate Finance Committee and the House Environmental Matters Committee of the General Assembly.

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

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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.

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

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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.

SECTION 12. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1996.".