Unofficial Copy **2004 Regular Session**
SB0819/037877/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL NO. 819
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, strike beginning with "establishing" in line 3 down through "City" in line 7 and substitute "requiring the Department of Health and Mental Hygiene to apply for a certain waiver under the federal Social Security Act"; strike beginning with "prohibiting" in line 9 down through "circumstances" in line 13 and substitute "requiring that certain services are not subject to a certain program"; strike beginning with "requiring" in line 18 down through the semicolon in line 19; in line 22, strike "and the Department of Aging"; and strike beginning with "requiring" in line 23 down through the semicolon in line 30.

On pages 1 and 2, strike beginning with "requiring" in line 32 on page 1 down through "system" in line 2 on page 2 and substitute "requiring the Department to submit the proposed waiver under this Act to the Legislative Policy Committee for its review and comment; requiring the Department to report on the status of a certain program; providing for the termination of a certain program; requiring the Department to implement a certain program initially by emergency regulation".

On page 2, in line 7, strike "15-115.1 and".

AMENDMENT NO. 2

On pages 2 and 3, strike in their entirety the lines beginning with line 18 on page 2 through line 27 on page 3, inclusive.

On page 4, in line 4, strike "(I)"; and in the same line, strike the bracket.

On pages 4 and 5, strike beginning with the bracket in line 9 on page 4 down through "FOOTAGE" in line 11 on page 5.

(Over)

On page 5, in line 25, strike the brackets; in lines 25 and 26, strike ": (I) DO"; in lines 29, 30, and 32, in each instance, strike the brackets; in the same lines, strike "1.", "2.", and "3.", respectively; and in line 33, strike "; OR" and substitute a period.

On page 6, strike line 1 in its entirety; in line 21, strike the opening bracket; and in the same line, strike "(c)] (F) AND (G)" and substitute "(D)".

On pages 6 through 8, strike in their entirety the lines beginning with line 31 on page 6 through line 5 on page 8, inclusive.

AMENDMENT NO. 3

On page 8, in line 6, in each instance, strike the bracket; in the same line, strike "(F)"; in the same line, strike "SEPTEMBER 1, 2004"; in line 7, strike the brackets; strike beginning with "CENTERS" in line 7 down through "SERVICES" in line 8; strike beginning with "AND" in line 12 down through "COMMUNITY" in line 15; after line 15, insert:

"(C) (1) IF PERMITTED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AN INDIVIDUAL SHALL BE DETERMINED MEDICALLY ELIGIBLE TO RECEIVE SERVICES UNDER THE WAIVER UNDER SUBSECTION (B) OF THIS SECTION IF THE INDIVIDUAL REQUIRES:

(I) SKILLED NURSING FACILITY CARE OR OTHER RELATED SERVICES;

(II) REHABILITATION SERVICES; OR

(III) HEALTH-RELATED SERVICES ABOVE THE LEVEL OF ROOM AND BOARD THAT ARE AVAILABLE ONLY THROUGH NURSING FACILITIES, INCLUDING INDIVIDUALS WHO BECAUSE OF SEVERE COGNITIVE IMPAIRMENTS OR OTHER CONDITIONS:

1. A. ARE CURRENTLY UNABLE TO PERFORM AT LEAST TWO ACTIVITIES OF DAILY LIVING WITHOUT HANDS-ON ASSISTANCE OR STANDBY ASSISTANCE FROM ANOTHER INDIVIDUAL; AND

B. HAVE BEEN OR WILL BE UNABLE TO PERFORM AT LEAST TWO ACTIVITIES OF DAILY LIVING FOR A PERIOD OF AT LEAST 90 DAYS DUE TO A LOSS OF FUNCTIONAL CAPACITY; OR

2. NEED SUBSTANTIAL SUPERVISION FOR PROTECTION AGAINST THREATS TO HEALTH AND SAFETY DUE TO SEVERE COGNITIVE IMPAIRMENT.

(2) THE DEPARTMENT SHALL ADOPT REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SUBSECTION.";

in line 16, strike "(G)" and substitute "(D)"; in line 17, strike "GOALS AND OBJECTIVES"; in line 18, strike "(I)"; and strike beginning with "TO" in line 18 down through "INDIVIDUAL" in line 39.

AMENDMENT NO. 4

On page 9, in lines 1, 3, 6, and 23, in each instance, strike the brackets; in lines 1, 3, 6, and 23, strike "(3)", "(4)", "(5)", and "(6)", respectively; and in line 15, after "(III)" insert "IF PERMITTED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES UNDER THE WAIVER UNDER SUBSECTION (B) OF THIS SECTION,".

On page 10, in line 2, strike the brackets; in line 6, strike "AND"; strike in their entirety lines 7 and 8; and in lines 9, 12, 13, 14, 16, 20, 23, 26, and 29, strike "(7)", "(8)", "(9)", "(10)", "(11)", "(H)", "(I)", "(J)", and "(K)", respectively, and substitute "(6)", "(7)", "(8)", "(9)", "(10)", "(E)", "(F)", "(G)", and "(H)", respectively.

On pages 10 and 11, strike in their entirety the lines beginning with line 32 on page 10 through line 16 on page 11, inclusive.

On page 11, after line 16, insert:

"(I) AT LEAST 25% OF THE INDIVIDUALS WHO QUALIFY FOR MEDICAL ASSISTANCE ELIGIBILITY UNDER THE WAIVER UNDER SUBSECTION (B) OF THIS SECTION SHALL BE PARTICIPANTS IN THE PROGRAM DESCRIBED IN § 15-141 OF THIS

SUBTITLE";
in lines 17 and 24, strike "(N)" and "(O)", respectively, and substitute "(J)" and "(K)", respectively; in line 24, strike the second set of brackets; in the same line, strike the colon; in line 25, strike "(1)"; in the same line, strike the brackets; in the same line, strike "THE"; in line 26, strike the bracket; in line 27, strike "(c)] (F) AND (G)" and substitute "(D)"; in the same line, strike "; AND"; and strike beginning with "(2)" in line 28 down through "SECTION" in line 31.

AMENDMENT NO. 5

On page 12, after line 1, insert:

"(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "COMMUNITY CARE ORGANIZATION" MEANS AN ORGANIZATION APPROVED BY THE DEPARTMENT THAT ARRANGES FOR HEALTH CARE SERVICES WITH THE GOAL OF PROMOTING THE DELIVERY OF SERVICES IN THE MOST APPROPRIATE, COST-EFFECTIVE SETTING.

(3) "COMMUNITY CHOICE PROGRAM" MEANS A PROGRAM THAT DELIVERS SERVICES IN ACCORDANCE WITH THE WAIVER DEVELOPED UNDER THIS SECTION.

(B) (1) ON OR BEFORE NOVEMBER 1, 2004, THE DEPARTMENT SHALL APPLY FOR A WAIVER UNDER THE FEDERAL SOCIAL SECURITY ACT.

(2) AS PERMITTED BY FEDERAL LAW OR WAIVER, THE SECRETARY MAY ESTABLISH A PROGRAM UNDER WHICH MEDICAID PROGRAM RECIPIENTS ARE REQUIRED TO ENROLL IN COMMUNITY CARE ORGANIZATIONS.

(3) CONSISTENT WITH THE FEDERAL WAIVER UNDER PARAGRAPH (1) OF THIS SUBSECTION, IF THE SECRETARY ESTABLISHES A PROGRAM UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE PROGRAM MAY NOT OPERATE IN MORE THAN TWO AREAS OF THE STATE.

(C) ANY WAIVER DEVELOPED UNDER THIS SECTION SHALL INCLUDE THE

FOLLOWING GOALS AND OBJECTIVES:

(1) INCREASING PARTICIPANT SATISFACTION;

(2) ALLOWING PARTICIPANTS TO AGE IN PLACE;

(3) REDUCING MEDICAID EXPENDITURES BY ENCOURAGING THE MOST APPROPRIATE UTILIZATION OF HIGH QUALITY SERVICES; AND

(4) ENHANCING COMPLIANCE WITH THE FEDERAL AMERICANS WITH DISABILITIES ACT BY OFFERING COST-EFFECTIVE COMMUNITY-BASED SERVICES IN THE MOST APPROPRIATE HIGH QUALITY AND LEAST RESTRICTIVE SETTING.

(D) (1) THE BENEFITS PROVIDED BY THE COMMUNITY CHOICE PROGRAM SHALL INCLUDE THOSE SERVICES AVAILABLE UNDER THE MEDICAID STATE PLAN AND SERVICES COVERED UNDER HOME AND COMMUNITY-BASED SERVICES WAIVERS.

(2) EXCEPT WHEN SERVICES ARE LIMITED OR EXCLUDED FROM THE COMMUNITY CHOICE PROGRAM BY THE SECRETARY, THE COMMUNITY CARE ORGANIZATION SHALL PROVIDE ALL THE SERVICES ESTABLISHED IN REGULATION AND REQUIRED BY THE SECRETARY.

(3) THE SECRETARY MAY EXCLUDE SPECIFIC POPULATIONS.

(4) THE SECRETARY SHALL INCLUDE A DEFINITION OF "MEDICAL NECESSITY" IN ITS QUALITY AND ACCESS STANDARDS.

(5) NOTHING IN THE COMMUNITY CHOICE PROGRAM MAY PRECLUDE A NURSING HOME FROM UTILIZING AN INSTITUTIONAL PHARMACY OF ITS OWN CHOICE FOR THE PROVISION OF INSTITUTIONAL PHARMACY SERVICES AND BENEFITS FOR WAIVER ENROLLEES IN THE NURSING HOME.

(E) COMMUNITY CHOICE PROGRAM RECIPIENTS SERVED BY THE PROGRAM

DEVELOPED UNDER THIS SECTION SHALL BE ALLOWED TO CHOOSE AMONG AT LEAST TWO COMMUNITY CARE ORGANIZATIONS THAT HAVE DEMONSTRATED A NETWORK CAPACITY SUFFICIENT TO MEET THE NEEDS OF THE POPULATION.

(F) (1) ON AN ANNUAL BASIS OR FOR CAUSE, AN ENROLLEE MAY CHOOSE TO DISENROLL FROM A COMMUNITY CARE ORGANIZATION AND ENROLL IN ANOTHER COMMUNITY CARE ORGANIZATION.

(2) EACH ENROLLEE RECEIVING SERVICES IN A NURSING HOME, AN ASSISTED LIVING FACILITY, OR AN ADULT DAY CARE FACILITY SHALL HAVE THE OPTION OF REMAINING IN THE NURSING HOME, ASSISTED LIVING FACILITY, OR ADULT DAY CARE FACILITY.

(3) AN ENROLLEE OF THE PROGRAM WHO QUALIFIES FOR NURSING LEVEL CARE MAY CHOOSE TO RECEIVE SERVICES IN A NURSING HOME OR IN THE COMMUNITY, IF THE COMMUNITY PLACEMENT IS COST-EFFECTIVE.

(4) THE COMMUNITY CHOICE PROGRAM SHALL ENSURE THAT ALL ENROLLEES IN THE PROGRAM MAINTAIN ACCESS TO PHARMACY BENEFITS, INCLUDING ALL CLASSES OF DRUGS, THAT ARE COMPARABLE TO THE BENEFITS PROVIDED IN THE MEDICAL ASSISTANCE PROGRAM.

(G) (1) EACH COMMUNITY CARE ORGANIZATION SHALL PROVIDE FOR THE BENEFITS DESCRIBED IN SUBSECTION (D) OF THIS SECTION.

(2) THIS SECTION MAY NOT BE CONSTRUED TO PREVENT A COMMUNITY CARE ORGANIZATION FROM PROVIDING ADDITIONAL BENEFITS THAT ARE NOT COVERED BY A CAPITATED RATE.

(3) (I) THE DEPARTMENT SHALL MAKE CAPITATION PAYMENTS TO EACH COMMUNITY CARE ORGANIZATION AS PROVIDED IN THIS PARAGRAPH.

(II) THE SECRETARY SHALL SET CAPITATION PAYMENTS AT A LEVEL THAT IS ACTUARIALLY ADJUSTED FOR THE BENEFITS PROVIDED.

(III) THE SECRETARY SHALL ADJUST CAPITATION PAYMENTS TO REFLECT THE RELATIVE RISK ASSUMED BY THE COMMUNITY CARE ORGANIZATION.

(H) THE DEPARTMENT SHALL REQUIRE COMMUNITY CARE ORGANIZATIONS TO BE CERTIFIED TO ACCEPT CAPITATED PAYMENTS FROM THE FEDERAL MEDICARE PROGRAM FOR INDIVIDUALS WHO ARE DUALLY ELIGIBLE.

(I) THE COMMUNITY CHOICE PROGRAM SHALL INCLUDE:

(1) ADULTS WHO ARE DUALLY ELIGIBLE;

(2) ADULT MEDICAID RECIPIENTS WHO MEET THE NURSING HOME LEVEL OF CARE STANDARD; AND

(3) MEDICAID RECIPIENTS OVER 65 YEARS OF AGE.

(J) (1) INDIVIDUALS ELIGIBLE FOR THE COMMUNITY CHOICE PROGRAM SHALL HAVE THE RIGHT TO ELECT TO RECEIVE SERVICES UNDER THE COMMUNITY CHOICE PROGRAM OR AN APPROVED PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.

(2) IF AN INDIVIDUAL ELIGIBLE FOR THE COMMUNITY CHOICE PROGRAM REQUIRES HOSPICE CARE, THE INDIVIDUAL SHALL ELECT TO RECEIVE HOSPICE CARE FROM A LICENSED HOSPICE PROGRAM UNDER A SEPARATE ARRANGEMENT AND PAYMENT FOR HOSPICE CARE PROVIDED TO THE INDIVIDUAL SHALL BE MADE DIRECTLY TO THE HOSPICE PROGRAM BY THE DEPARTMENT UNDER THE MEDICAID-ESTABLISHED RATE FOR HOSPICE CARE REIMBURSEMENT.

(K) (1) EACH COMMUNITY CARE ORGANIZATION SHALL MEET ALL REQUIREMENTS FOR CERTIFICATION BY THE DEPARTMENT.

(2) EACH COMMUNITY CARE ORGANIZATION SHALL:

(I) HAVE A QUALITY ASSURANCE PROGRAM, SUBJECT TO APPROVAL BY THE SECRETARY, WHICH SHALL:

1. PROVIDE FOR AN ENROLLEE GRIEVANCE SYSTEM, INCLUDING AN ENROLLEE HOTLINE;

2. PROVIDE FOR A PROVIDER GRIEVANCE SYSTEM, INCLUDING A PROVIDER HOTLINE;

3. PROVIDE FOR AN ENROLLEE SATISFACTION SURVEY; AND

4. PROVIDE FOR A CONSUMER ADVISORY BOARD TO RECEIVE REGULAR INPUT FROM ENROLLEES AND SUBMIT AN ANNUAL REPORT OF THE ADVISORY BOARD TO THE SECRETARY;

(II) SUBMIT SERVICE-SPECIFIC DATA IN A FORMAT SPECIFIED BY THE SECRETARY;

(III) INCLUDE PROVISIONS FOR CONSUMER DIRECTION OF PERSONAL ASSISTANCE SERVICES;

(IV) ENSURE NECESSARY PROVIDER CAPACITY IN ALL GEOGRAPHIC REGIONS WHERE THE COMMUNITY CARE ORGANIZATION IS APPROVED TO OPERATE;

(V) BE ACCOUNTABLE, AND HOLD ITS SUBCONTRACTORS ACCOUNTABLE, FOR MEETING ALL REQUIREMENTS, STANDARDS, CRITERIA, OR OTHER DIRECTIVES OF THE DEPARTMENT AND UPON FAILURE TO MEET THOSE STANDARDS, BE SUBJECT TO ONE OR MORE OF THE FOLLOWING PENALTIES:

1. FINES;

2. SUSPENSION OF FURTHER ENROLLMENT;

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

4. TERMINATION OF A CONTRACT;

5. DISQUALIFICATION FROM FUTURE PARTICIPATION; AND

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

(VI) MEET THE SOLVENCY AND CAPITAL REQUIREMENTS FOR HEALTHCHOICE MANAGED CARE ORGANIZATIONS UNDER THE INSURANCE ARTICLE;

(VII) TO THE EXTENT PRACTICABLE, ALLOW WAIVER ENROLLEES, WHO MEET THE NURSING HOME LEVEL OF CARE, TO SELECT A NURSING HOME, ASSISTED LIVING FACILITY, OR ADULT DAY CARE FACILITY PROVIDED THAT THE NURSING HOME, ASSISTED LIVING FACILITY, OR ADULT DAY CARE FACILITY IS LICENSED BY THE DEPARTMENT AND THE PROVIDER MEETS THE DEPARTMENT-APPROVED CREDENTIALING REQUIREMENTS OF THE COMMUNITY CARE ORGANIZATION;

(VIII) SUBMIT TO THE DEPARTMENT UTILIZATION AND OUTCOME REPORTS AS DIRECTED BY THE DEPARTMENT;

(IX) PROVIDE TIMELY ACCESS TO, AND CONTINUITY OF, HEALTH AND LONG-TERM CARE SERVICES FOR ENROLLEES;

(X) DEMONSTRATE ORGANIZATIONAL CAPACITY TO PROVIDE SPECIAL POPULATION SERVICES, INCLUDING OUTREACH, CASE MANAGEMENT, AND HOME VISITING, DESIGNED TO MEET THE INDIVIDUAL NEEDS OF ALL ENROLLEES;

(XI) PROVIDE ASSISTANCE TO ENROLLEES IN SECURING NECESSARY HEALTH AND LONG-TERM CARE SERVICES; AND

(XII) COMPLY WITH ALL RELEVANT PROVISIONS OF THE FEDERAL BALANCED BUDGET ACT OF 1997 (P.L. 105-33).

(L) A COMMUNITY CARE ORGANIZATION MAY NOT HAVE FACE-TO-FACE OR TELEPHONE CONTACT OR OTHERWISE SOLICIT AN INDIVIDUAL FOR THE PURPOSE OF ENROLLMENT UNDER THE PROGRAM.

(M) (1) IN ARRANGING FOR THE BENEFITS REQUIRED UNDER SUBSECTION (D) OF THIS SECTION, THE COMMUNITY CARE ORGANIZATION SHALL:

(I) A. REIMBURSE NURSING HOMES NOT LESS THAN THE MEDICAID-ESTABLISHED RATE BASED ON THE WAIVER RECIPIENT'S MEDICAL CONDITION PLUS ALLOWABLE ANCILLARY SERVICES, AS ESTABLISHED BY THE DEPARTMENT BASED ON ITS NURSING HOME MEDICAID RATE SETTING METHODOLOGY; OR

B. FOR WAIVER RECIPIENTS THAT WOULD HAVE BEEN PAID BY THE MEDICARE PROGRAM FOR SERVICES PROVIDED, REIMBURSE NURSING HOMES NOT LESS THAN THE APPLICABLE REIMBURSEMENT RATE PAYABLE BY MEDICARE FOR THAT WAIVER RECIPIENT;

(II) REIMBURSE NURSING HOMES IN ACCORDANCE WITH THE DEPARTMENT'S POLICY ON LEAVE OF ABSENCE AS PROVIDED UNDER § 15-117 OF THIS SUBTITLE;

(III) REIMBURSE ADULT DAY CARE FACILITIES NOT LESS THAN THE RATE DETERMINED BY THE DEPARTMENT FOR THE MEDICAL ASSISTANCE PROGRAM;

(IV) REIMBURSE HOSPITALS IN ACCORDANCE WITH THE RATES ESTABLISHED BY THE HEALTH SERVICES COST REVIEW COMMISSION;

(V) FOR ENROLLEES WITH COMPLEX, LONG-TERM CARE NEEDS, USE A COMPREHENSIVE CARE AND SUPPORT MANAGEMENT TEAM, INCLUDING THE PRIMARY CARE PROVIDER, NURSE MANAGER, CASE MANAGER, AND OTHERS AS APPROPRIATE; AND

(VI) REIMBURSE A HOSPITAL EMERGENCY FACILITY AND PROVIDER FOR:

1. HEALTH CARE SERVICES THAT MEET THE DEFINITION OF EMERGENCY SERVICES UNDER § 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 COMMUNITY 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 BY THE PROVIDER IN THE EMERGENCY FACILITY TO THE ENROLLEE IF THE COMMUNITY CARE ORGANIZATION FAILS TO PROVIDE 24-HOUR ACCESS TO A PHYSICIAN AS REQUIRED BY THE DEPARTMENT.

(2) A PROVIDER MAY NOT BE REQUIRED TO OBTAIN PRIOR AUTHORIZATION OR APPROVAL FOR PAYMENT FROM A COMMUNITY CARE ORGANIZATION IN ORDER TO OBTAIN REIMBURSEMENT UNDER PARAGRAPH (1) (VI) OF THIS SUBSECTION.

(3) NOTHING IN THIS SUBSECTION PROHIBITS A COMMUNITY CARE ORGANIZATION FROM PROVIDING A BONUS OR INCENTIVE FOR QUALITY IMPROVEMENTS.

(N) SAVINGS FROM THE PROGRAM DEVELOPED UNDER THIS SECTION MAY BE USED TO:

(1) ASSIST MEDICALLY AND FUNCTIONALLY IMPAIRED INDIVIDUALS IN THE COMMUNITY, OR WHEN DISCHARGED FROM A HOSPITAL, TO RECEIVE HOME- AND COMMUNITY-BASED WAIVER SERVICES;

(2) INCREASE REIMBURSEMENT RATES TO COMMUNITY PROVIDERS; AND

(3) DEVELOP A STATEWIDE SINGLE POINT-OF-ENTRY SYSTEM CONSISTING OF A DESIGNATED ENTITY IN EACH COUNTY AND BALTIMORE CITY TO:

(I) ACCEPT APPLICATIONS;

(II) MAKE ALL ELIGIBILITY DETERMINATIONS;

(III) ENROLL INDIVIDUALS IN THE PROGRAM; AND

(IV) PROVIDE COORDINATED SERVICES, INCLUDING:

1. LEVEL-OF-CARE DETERMINATIONS;

2. FINANCIAL DETERMINATIONS;

3. PLAN OF CARE DETERMINATIONS;

4. CASE MANAGEMENT SERVICES; AND

5. OTHER SERVICES AS NEEDED.

(O) IN DEVELOPING THE WAIVER APPLICATION AND REGULATIONS UNDER THIS SECTION, THE DEPARTMENT SHALL SOLICIT INPUT FROM, AND CONSULT WITH, REPRESENTATIVES OF INTERESTED AND AFFECTED PARTIES, INCLUDING:

(1) LEGISLATORS;

(2) AFFECTED STATE AGENCIES;

(3) PROVIDERS WITH EXPERTISE IN DEMENTIA, GERIATRICS, END-OF-LIFE CARE, AND MENTAL HEALTH;

(4) LONG-TERM CARE PROVIDERS;

(5) MANAGED CARE ORGANIZATIONS;

(6) ACUTE CARE PROVIDERS;

(7) LAY CARE GIVERS;

(8) ADVOCATES FOR WAIVER-ELIGIBLE CANDIDATES; AND

(9) CONSUMERS.".

AMENDMENT NO. 6

On page 12, in line 2, before "THE" insert "(P)"; in the same line, strike "OBTAIN LEGISLATIVE APPROVAL" and substitute a comma; strike beginning with "ANY" in line 3 down through "ACT" in line 4 and substitute "THE WAIVER UNDER THIS SECTION, SUBMIT THE PROPOSED WAIVER TO THE LEGISLATIVE POLICY COMMITTEE FOR ITS REVIEW AND COMMENT"; strike beginning with the second "and" in line 6 down through "2004" in line 13 and substitute "shall annually report to the General Assembly beginning on December 1, 2004, in accordance with § 2-1246 of the State Government Article, on the status of the program developed under § 15-141 of the Health - General Article as enacted by this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene shall initially submit emergency regulations to begin implementation of the program developed under § 15-141 of the Health - General Article as enacted by this Act.

SECTION 4. AND BE IT FURTHER ENACTED, That unless further action is taken by the General Assembly, the program developed under § 15-141 of the Health - General Article as enacted by this Act shall terminate at the end of May 31, 2008";

and in line 14, strike "3." and substitute "5.".