SENATE BILL 189

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By: **Chairman, Finance Committee (Departmental - Health and Mental Hygiene)**
Introduced and read first time: January 24, 2000
Assigned to: Finance

Committee Report: Favorable
Senate action: Adopted with floor amendments
Read second time: February 15, 2000

CHAPTER_____

AN ACT concerning

Maryland Health Care Commission - Modifications and Clarifications

FOR the purpose of repealing the authority of the Maryland Health Care Commission to develop a payment system for health care services; altering a certain definition; altering certain provisions relating to the publishing of certain information related to reimbursements from payors; authorizing the Commission to promote the availability of certain information on charges by practitioners and reimbursements from payors; authorizing the Commission to impose certain requirements on payors; and generally relating to the Maryland Health Care Commission.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-103 and 19-134
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing
Article - Health - General
Section 19-136
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY renumbering
Article - Health - General

Section 19-137 through 19-139, respectively
to be Section 19-136 through 19-138, respectively
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health - General

19-103.

(a) There is a Maryland Health Care Commission.

(b) The Commission is an independent commission that functions in the Department.

(c) The purpose of the Commission is to:

(1) Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission;

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by:

(i) Advocating policies and systems to promote the efficient delivery of and improved access to health care services; AND

(ii) Enhancing the strengths of the current health care service delivery and regulatory system;

(3) Facilitate the public disclosure of medical claims data for the development of public policy;

(4) Establish and develop a medical care data base on health care services rendered by health care practitioners;

(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services;

(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop:

(i) A uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan; and

(ii) A modified health benefit plan for medical savings accounts;

(7) Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners;

(8) Ensure utilization of the medical care data base as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

(9) [Develop a payment system for health care services;

(10)] Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland;

[(11)] (10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors;

[(12)] (11) Develop a uniform set of effective benefits to be offered as substantial, available, and affordable coverage in the nongroup market in accordance with § 15-606 of the Insurance Article; [and]

[(13)] (12) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article; AND

(13) PROMOTE THE AVAILABILITY OF INFORMATION TO CONSUMERS ON CHARGES BY PRACTITIONERS AND REIMBURSEMENTS FROM PAYORS.

(d) The Commission shall coordinate the exercise of its functions with the Department and the Health Services Cost Review Commission to ensure an integrated, effective health care policy for the State.

19-134.

(A) ~~IN THIS SECTION, "CODE" MEANS THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION OR OTHER APPLICABLE CODE UNDER AN APPROPRIATE UNIFORM CODING SCHEME APPROVED BY THE COMMISSION.~~ IN THIS SECTION, "CODE" MEANS:

(1) THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION; OR

(2) IF A CPT CODE IS NOT AVAILABLE, THE APPLICABLE CODE UNDER AN APPROPRIATE UNIFORM CODING SCHEME APPROVED BY THE COMMISSION.

[(a)] (B) The Commission shall establish a Maryland medical care data base to compile statewide data on health services rendered by health care practitioners and office facilities selected by the Commission.

[(b)] (C) In addition to any other information the Commission may require by regulation, the medical care data base shall:

(1) Collect for each type of patient encounter with a health care practitioner or office facility designated by the Commission:

(i) The demographic characteristics of the patient;

(ii) The principal diagnosis;

(iii) The procedure performed;

(iv) The date and location of where the procedure was performed;

(v) The charge for the procedure;

(vi) If the bill for the procedure was submitted on an assigned or nonassigned basis;

(vii) If applicable, a health care practitioner's universal identification number; and

(viii) If the health care practitioner rendering the service is a certified registered nurse anesthetist or certified nurse midwife, identification modifiers for the certified registered nurse anesthetist or certified nurse midwife;

(2) Collect appropriate information relating to prescription drugs for each type of patient encounter with a pharmacist designated by the Commission; and

(3) Collect appropriate information relating to health care costs, utilization, or resources from payors and governmental agencies.

[(c)] (D) (1) The Commission shall adopt regulations governing the access and retrieval of all medical claims data and other information collected and stored in the medical care data base and any claims clearinghouse licensed by the Commission and may set reasonable fees covering the costs of accessing and retrieving the stored data.

(2) These regulations shall ensure that confidential or privileged patient information is kept confidential.

(3) Records or information protected by the privilege between a health care practitioner and a patient, or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the person protected.

[(d)] (E) (1) To the extent practicable, when collecting the data required under subsection [(b)] (C) of this section, the Commission shall utilize any standardized claim form or electronic transfer system being used by health care practitioners, office facilities, and payors.

(2) The Commission shall develop appropriate methods for collecting the data required under subsection [(b)] (C) of this section on subscribers or enrollees of health maintenance organizations.

[(e)] (F) Until the provisions of § 19-135 of this subtitle are fully implemented, where appropriate, the Commission may limit the data collection under this section.

[(f)] (G) (1) By October 1, 1995 and each year thereafter, the Commission shall publish an annual report on those health care services selected by the Commission that:

[(1)] (I) Describes the variation in fees charged by health care practitioners and office facilities on a statewide basis and in each health service area for those health care services; and

[(2)] (II) Describes the geographic variation in the utilization of those health care services.

(2) (I) ON AN ANNUAL BASIS, THE COMMISSION SHALL PUBLISH:

1. THE TOTAL REIMBURSEMENT FOR ALL HEALTH CARE SERVICES OVER A 12-MONTH PERIOD;

2. THE TOTAL REIMBURSEMENT FOR EACH HEALTH CARE SPECIALITY OVER A 12-MONTH PERIOD;

3. THE TOTAL REIMBURSEMENT FOR EACH CODE OVER A 12-MONTH PERIOD; AND

4. THE ANNUAL RATE OF CHANGE IN REIMBURSEMENT FOR HEALTH SERVICES BY HEALTH CARE SPECIALTIES AND BY CODE.

(II) IN ADDITION TO THE INFORMATION REQUIRED UNDER ITEM (I) OF THIS PARAGRAPH, THE COMMISSION MAY PUBLISH ANY OTHER INFORMATION THAT THE COMMISSION DEEMS APPROPRIATE, INCLUDING INFORMATION ON CAPITATED HEALTH CARE SERVICES.

[(g)] (H) In developing the medical care data base, the Commission shall consult with representatives of the Health Services Cost Review Commission, health care practitioners, payors, and hospitals to ensure that the medical care data base is compatible with, may be merged with, and does not duplicate information collected by the Health Services Cost Review Commission.

(i) The Commission, in consultation with the Insurance Commissioner, payors, health care practitioners, and hospitals, may adopt by regulation standards for the electronic submission of data and submission and transfer of the uniform claims forms established under § 15-1003 of the Insurance Article.

[19-136.

(a) (1) In this section the following words have the meanings indicated.

(2) "Code" means the applicable Current Procedural Terminology (CPT) code as adopted by the American Medical Association or other applicable code under an appropriate uniform coding scheme approved by the Commission.

(3) "Payor" means:

(i) A health insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in the State in accordance with the Insurance Article or the Health - General Article; or

(ii) A health maintenance organization that holds a certificate of authority.

(4) Unbundling means the use of two or more codes by a health care provider to describe a surgery or service provided to a patient when a single, more comprehensive code exists that accurately describes the entire surgery or service.

(b) (1) By January 1, 1999, the Commission shall implement a payment system for all health care practitioners in the State.

(2) The payment system established under this section shall include a methodology for a uniform system of health care practitioner reimbursement.

(3) Under the payment system, reimbursement for each health care practitioner shall be comprised of the following numeric factors:

(i) A numeric factor representing the resources of the health care practitioner necessary to provide health care services;

(ii) A numeric factor representing the relative value of a health care service, as classified by a code, compared to that of other health care services; and

(iii) A numeric factor representing a conversion modifier used to adjust reimbursement.

(4) To prevent overpayment of claims for surgery or services, in developing the payment system under this section, the Commission, to the extent practicable, shall establish standards to prohibit the unbundling of codes and the use of reimbursement maximization programs, commonly known as "upcoding".

(5) In developing the payment system under this section, the Commission shall consider the underlying methodology used in the resource based relative value scale established under 42 U.S.C. § 1395w-4.

(6) The Commission and the licensing boards shall develop, by regulation, appropriate sanctions, including, where appropriate, notification to the Insurance Fraud Unit of the State, for health care practitioners who violate the standards established by the Commission to prohibit unbundling and upcoding.

(c) (1) In establishing a payment system under this section, the Commission shall take into consideration the factors listed in this subsection.

(2) In making a determination under subsection (b)(3)(i) of this section concerning the resources of a health care practitioner necessary to deliver health care services, the Commission:

(i) Shall ensure that the compensation for health care services is reasonably related to the cost of providing the health care service; and

(ii) Shall consider:

1. The cost of professional liability insurance;

2. The cost of complying with all federal, State, and local regulatory requirements;

3. The reasonable cost of bad debt and charity care;

4. The differences in experience or expertise among health care practitioners, including recognition of relative preeminence in the practitioner's field or specialty and the cost of education and continuing professional education;

5. The geographic variations in practice costs;

6. The reasonable staff and office expenses deemed necessary by the Commission to deliver health care services;

7. The costs associated with a faculty practice plan affiliated with a teaching hospital; and

8. Any other factors deemed appropriate by the Commission.

(3) In making a determination under subsection (b)(3)(ii) of this section concerning the value of a health care service relative to other health care services, the Commission shall consider:

(i) The relative complexity of the health care service compared to that of other health care services;

(ii) The cognitive skills associated with the health care service;

(iii) The time and effort that are necessary to provide the health care service; and

(iv) Any other factors deemed appropriate by the Commission.

(4) Except as provided under subsection (d) of this section, a conversion modifier shall be:

(i) A payor's standard for reimbursement;

(ii) A health care practitioner's standard for reimbursement; or

(iii) Arrangements agreed upon between a payor and a health care practitioner.

(d) (1) (i) The Commission may make an effort, through voluntary and cooperative arrangements between the Commission and the appropriate health care practitioner specialty group, to bring that health care practitioner specialty group into compliance with the health care cost goals of the Commission if the Commission determines that:

1. Certain health care services are significantly contributing to unreasonable increases in the overall volume and cost of health care services;

2. Health care practitioners in a specialty area have attained unreasonable levels of reimbursable services under a specific code in comparison to health care practitioners in another specialty area for the same code;

3. Health care practitioners in a specialty area have attained unreasonable levels of reimbursement, in terms of total compensation, in comparison to health care practitioners in another specialty area;

4. There are significant increases in the cost of providing health care services; or

5. Costs in a particular health care specialty vary significantly from the health care cost annual adjustment goal established under subsection (f) of this section.

(ii) If the Commission determines that voluntary and cooperative efforts between the Commission and appropriate health care practitioners have been unsuccessful in bringing the appropriate health care practitioners into compliance with the health care cost goals of the Commission, the Commission may adjust the conversion modifier.

(2) If the Commission adjusts the conversion modifier under this subsection for a particular specialty group, a health care practitioner in that specialty group may not be reimbursed more than an amount equal to the amount determined according to the factors set forth in subsection (b)(3)(i) and (ii) of this section and the conversion modifier established by the Commission.

(e) (1) On an annual basis, the Commission shall publish:

(i) The total reimbursement for all health care services over a 12-month period;

(ii) The total reimbursement for each health care specialty over a 12-month period;

(iii) The total reimbursement for each code over a 12-month period; and

(iv) The annual rate of change in reimbursement for health services by health care specialties and by code.

(2) In addition to the information required under paragraph of this subsection, the Commission may publish any other information that the Commission deems appropriate.

(f) The Commission may establish health care cost annual adjustment goals for the cost of health care services and may establish the total cost of health care services by code to be rendered by a specialty group of health care practitioners designated by the Commission during a 12-month period.

(g) In developing a health care cost annual adjustment goal under subsection (f) of this section, the Commission shall:

(1) Consult with appropriate health care practitioners, payors, the Association of Maryland Hospitals and Health Systems, the Health Services Cost Review Commission, the Department of Health and Mental Hygiene, and the Department of Business and Economic Development; and

(2) Take into consideration:

(i) The input costs and other underlying factors that contribute to the rising cost of health care in the State and in the United States;

(ii) The resources necessary for the delivery of quality health care;

(iii) The additional costs associated with aging populations and new technology;

(iv) The potential impacts of federal laws on health care costs; and

(v) The savings associated with the implementation of modified practice patterns.

(h) Nothing in this section shall have the effect of impairing the ability of a health maintenance organization to contract with health care practitioners or any other individual under mutually agreed upon terms and conditions.

(i) A professional organization or society that performs activities in good faith in furtherance of the purposes of this section is not subject to criminal or civil liability under the Maryland Anti-Trust Act for those activities.]

SECTION 2. AND BE IT FURTHER ENACTED, That Section(s) 19-137 through 19-139, respectively, of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 19-136 through 19-138, respectively.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2000.