Unofficial Copy **1998 Regular Session**
SB0521/797754/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL NO. 521
(First Reading File Bill)

AMENDMENT NO. 1

On pages 1 and 2, strike in their entirety the lines beginning with line 3 on page 1 through line 8 on page 2, inclusive, and substitute:

"FOR the purpose of transferring certain health planning and development functions from the Health Resources Planning Commission to the Department of Health and Mental Hygiene; requiring the Health Services Cost Review Commission to prepare a certain annual report and make available certain hospital outpatient data; permitting the Health Services Cost Review Commission to allow hospitals to charge below Commission-approved rates for certain services under certain circumstances; transferring the complaint system for members and subscribers of health maintenance organizations from the Department to the Maryland Insurance Commissioner; directing the Health Care Access and Cost Commission to promote the availability of information to consumers on charges by practitioners and reimbursements from payors; requiring the Health Care Access and Cost Commission to collect certain data regarding certified registered nurse anesthetists and certified nurse midwives; repealing the authority of the Health Care Access and Cost Commission to implement a certain payment system; directing the Commission to require payors to use rebundling edits and make the standards for rebundling available to the public; authorizing the Commission to publish information on capitated health care services; altering the procedure by which the Commission may adopt a practice parameter; transferring the administrative and enforcement responsibility for private review agents to the Insurance Commissioner; requiring a certain uniform claims form to include certain information; requiring a study and report on the certificate of need program; requiring certain data on freestanding ambulatory surgery to be collected in a certain manner and to meet certain requirements; requiring a study and report regarding financing of uncompensated care; requiring the establishment of a small group insurance market coordinating task force; requiring the establishment of an interagency task force to coordinate analysis of and report on downstream risk arrangements; requiring a

(Over)

certain quality of care study and report; requiring a study and report on practice parameters; requiring a study, development of a methodology, and a report on hospital licensed bed capacity; requiring the Department to implement the methodology through regulation by a certain date; authorizing the transfer of staff necessary to develop the State health plan; restricting the implementation of the changes to hospital outpatient rate regulation enacted by this Act; requiring a report on those changes; providing for the termination of the changes to hospital outpatient rate regulation; defining certain terms; and generally relating to health care regulatory responsibilities and duties.".

AMENDMENT NO. 2

On pages 2 and 3, strike in their entirety the lines beginning with line 9 on page 2 through line 1 on page 3, inclusive, and substitute:

"BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-101(i), 19-110, 19-111, 19-114, 19-122(b), 19-201, 19-217, 19-705.2, 19-1502, 19-1507(a) and (b), 19-1509, 19-1606
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY adding to
Article - Health - General
Section 19-201.5
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)".

On pages 3 and 4, strike in their entirety the lines beginning with line 15 on page 3 through line 38 on page 4, inclusive.

On page 5, strike line 3 in its entirety and substitute "Section 15-1001 and 15-1003(c)"; in line 13, strike "3" and substitute "1".

On pages 5 and 6, strike in their entirety the lines beginning with line 14 on page 5 through line 25 on page 6, inclusive.

On page 6, in line 26, strike "SECTION 3. AND BE IT FURTHER ENACTED" and substitute "SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND"; strike in their entirety lines 32 through 35, inclusive; and in line 36, strike "6." and substitute "2.".

AMENDMENT NO. 3

On pages 7 through 43, strike in their entirety the lines beginning with line 2 on page 7 through line 23 on page 43, inclusive, and substitute:

"19-101.

(i) "Local health planning agency" means a body that the [Commission] DEPARTMENT designates to perform health planning and development functions for a health service area.

19-110.

(a) In accordance with criteria that the [Commission] DEPARTMENT sets, the Governor shall designate health service areas in this State.

(b) After a 1-year period, the Governor may review or revise the boundaries of a health service area or increase the number of health service areas, on the Governor's initiative, at the request of the [Commission] DEPARTMENT, at the request of a local government, or at the request of a local health planning agency. Revisions to boundaries of health service areas shall be done in accordance with the criteria established by the [Commission] DEPARTMENT and with the approval of the legislature.

(c) Within 45 days of receipt of the State health plan or a change in the State health plan, the plan becomes effective unless the Governor notifies the [Commission] DEPARTMENT of his intent to modify or revise the State health plan adopted by the [Commission] DEPARTMENT.

19-111.

(a) The [Commission] DEPARTMENT shall designate, for each health service area, not

more than 1 local health planning agency.

(B) Local health systems agencies shall be designated as the local health planning agency for a one-year period beginning October 1, 1982, provided that the local health systems agency has:

(1) Full or conditional designation by the federal government by October 1, 1982;

(2) The ability to perform the functions prescribed in subsection [(c)] (D) of this section; or

(3) Received the support of the local governments in the areas in which the agency is to operate.

[(b)] (C) The [Commission] DEPARTMENT shall establish by [regulations] REGULATION criteria for designation of local health planning agencies.

[(c)] (D) Applicants for designation as the local health planning agency shall, at a minimum, be able to:

(1) Assure broad citizen representation, including a board with a consumer majority; AND

(2) Develop a local health plan by assessing local health needs and resources, establishing local standards and criteria for service characteristics, consistent with State specifications, and setting local goals and objectives for systems development[;

(3) Provide input into the development of statewide criteria and standards for certificate of need and health planning; and

(4) Provide input into evidentiary hearings on the evaluation of certificate of need applications from its area. Where no local health planning agency is designated, the Commission shall seek the advice of the local county government of the affected area].

(E) (1) THE COMMISSION SHALL ESTABLISH CRITERIA FOR OBTAINING INPUT FROM AFFECTED LOCAL HEALTH PLANNING AGENCIES WHEN CONSIDERING AN

APPLICATION FOR CERTIFICATE OF NEED.

(2) WHERE NO LOCAL HEALTH PLANNING AGENCY IS DESIGNATED, THE COMMISSION SHALL SEEK THE ADVICE OF THE LOCAL COUNTY GOVERNMENT OF THE AFFECTED AREA.

[(d)] (F) The [Commission] DEPARTMENT shall require that in developing local health plans, each local health planning agency:

(1) Use the population estimates that the Department prepares under § 4-218 of this article;

(2) Use the figures and special age group projections that the Office of Planning prepares annually for the [Commission] DEPARTMENT;

(3) Meet applicable planning specifications; and

(4) Work with other local health planning agencies to ensure consistency among local health plans.

(G) PRIOR TO THE ADOPTION OF A STATE HEALTH PLAN UNDER § 19-114 OF THIS SUBTITLE, THE DEPARTMENT SHALL PROVIDE THE OPPORTUNITY FOR LOCAL HEALTH PLANNING AGENCIES TO SUBMIT TO THE DEPARTMENT INFORMATION ON LOCAL HEALTH NEEDS AND RESOURCES AS IDENTIFIED IN LOCAL HEALTH PLANS.

19-114.

(a) (1) At least every 5 years, beginning no later than October 1, 1983, the [Commission] DEPARTMENT shall adopt a State health plan that includes local health plans.

(2) The plan shall include:

(i) A description of the components that should comprise the health care system;

(ii) The goals and policies for Maryland's health care system;

(iii) Identification of unmet needs, excess services, minimum access criteria, and services to be regionalized;

(iv) An assessment of the financial resources required and available for the health care system;

(v) The methodologies, standards, and criteria for certificate of need review; and

(vi) Priority for conversion of acute capacity to alternative uses where appropriate.

(b) The [Commission] DEPARTMENT shall adopt specifications for the development of local health plans and their coordination with the State health plan.

(c) Annually or upon petition by any person, the [Commission] DEPARTMENT shall review the State health plan and publish any changes in the plan that the [Commission] DEPARTMENT considers necessary, subject to the review and approval granted to the Governor under this subtitle.

(d) The [Commission] DEPARTMENT shall adopt rules and regulations that ensure broad public input, public hearings, and consideration of local health plans in development of the State health plan.

(e) The [Commission] DEPARTMENT shall include standards and policies in the State health plan that relate to the certificate of need program. The standards shall address the availability, accessibility, cost, and quality of health care. The standards are to be reviewed and revised periodically to reflect new developments in health planning, delivery, and technology. In adopting standards regarding cost, efficiency, cost-effectiveness, or financial feasibility, the [Commission] DEPARTMENT may take into account the relevant methodologies of the Health Services Cost Review Commission.

[(f) Annually, the Secretary shall make recommendations to the Commission on the plan.

The Secretary may review and comment on State specifications to be used in the development of the State health plan.]

(F) THE DEPARTMENT MAY, IN CONSULTATION WITH THE COMMISSION, DELEGATE TO THE COMMISSION THE PLANNING FUNCTIONS NECESSARY TO SUPPORT THE CERTIFICATE OF NEED PROGRAM.

(g) All State agencies and departments, directly or indirectly involved with or responsible for any aspect of regulating, funding, or planning for the health care industry or persons involved in it, shall carry out their responsibilities in a manner consistent with the State health plan and available fiscal resources.

(h) In carrying out its responsibilities under this [Act] SUBTITLE for hospitals, the [Commission] DEPARTMENT shall recognize [and] BUT MAY not apply, [not] develop, or [not] duplicate standards or requirements related to quality which have been adopted and enforced by national or State licensing or accrediting authorities.

19-122.

(b) (1) The Commission, in lieu of the application fees provided for in § 19-115(b) of this subtitle, shall impose a user fee on facilities.

(2) Notwithstanding paragraph (3) of this subsection, the total user fees assessed by the Commission may not exceed $3,250,000 in any fiscal year.

(3) The total user fees assessed by the Commission may not exceed the special fund appropriation for the Commission AND FOR THE HEALTH PLANNING FUNCTIONS OF THE DEPARTMENT UNDER THIS SUBTITLE by more than 20%.

(4) The Commission shall pay all funds collected from fees assessed in accordance with this section into the Health Resources Planning Commission Fund.

(5) All user fee revenue assessed by the Commission:

(I) [shall] SHALL be used exclusively to cover:

1. [the] THE actual documented direct and indirect costs of fulfilling the statutory and regulatory duties of the Commission in accordance with the provisions of this subtitle[,] ; and

2. THE HEALTH PLANNING FUNCTIONS OF THE DEPARTMENT UNDER THIS SUBTITLE; AND

(II) [may] MAY only be expended for purposes authorized by the provisions of this subtitle. ".

AMENDMENT NO. 4

On page 43, in line 24, strike "19-128." and substitute "19-201."; in line 25, strike the brackets; in the same line, strike "PART III OF THIS SUBTITLE"; in line 27, strike the opening bracket; in line 28, strike the closing bracket; in line 31, strike the brackets; and in the same line, strike "(C)".

On page 44, in line 7, strike the brackets; in the same line, strike "(D)"; in line 14, strike "19-129." and substitute "19-201.5."; in line 16, strike "IN THIS PART III OF THIS SUBTITLE"; in line 21, strike "PART III; AND" and substitute "SUBTITLE;"; in line 26, strike the period and substitute "; AND

(3) (I) MAKE AVAILABLE TO THE PUBLIC ON AN ANNUAL BASIS DATA ON CHARGES, REVENUES, UTILIZATION, AND COSTS FOR HOSPITAL OUTPATIENT SURGICAL SERVICES FOR WHICH THE COMMISSION HAS PROVIDED ADDITIONAL PRICING FLEXIBILITY PURSUANT TO § 19-217 OF THIS SUBTITLE; AND

(II) ENSURE, BY SPECIAL AUDIT IF NECESSARY, THAT ALL OF THESE DATA ARE ACCURATE, AND THAT THE COST DATA REFLECT THE TRUE AND FULL COST OF PROVIDING THESE SERVICES.";

and in line 28, strike "PART III" and substitute "SUBTITLE".

On page 45, in line 4, strike "PART III" and substitute "SUBTITLE".

On pages 45 through 51, strike in their entirety the lines beginning with line 8 on page 45 through line 25 on page 51.

AMENDMENT NO. 5

On page 51, in line 26, strike "19-139." and substitute "19-217.".

On page 52, in line 4, strike the brackets; in the same line, strike "§ 19-141"; in line 7, strike "SHALL" and substitute "MAY"; in line 12, strike "INDIVIDUALS WITHOUT HEALTH INSURANCE COVERAGE" and substitute "ALL PATIENTS"; in the same line, strike "AND" and substitute:

"(II) THE COMMISSION DETERMINES THAT THE RATES FOR THESE HOSPITAL OUTPATIENT SURGICAL SERVICES ARE ADEQUATE; AND";

in line 13, strike "(II)" and substitute "(III)"; and strike in their entirety lines 17 through 31, inclusive.

On page 53, in line 8, strike the brackets; and in the same line, strike "PART II OF THIS SUBTITLE".

AMENDMENT NO. 6

On pages 53 through 59, strike in their entirety the lines beginning with line 17 on page 53 through line 14 on page 59, inclusive, and substitute:

"19-705.2.

(a) With the advice of the [Commissioner] SECRETARY, the [Secretary] COMMISSIONER shall adopt regulations to establish a system for the receipt and timely investigation of complaints of members and subscribers of health maintenance organizations concerning the operation of any health maintenance organization in this State.

(b) The complaint system shall include:

(1) A procedure for the timely acknowledgement of receipt of a complaint;

(2) Criteria THAT THE SECRETARY SHALL ADOPT BY REGULATION for determining the appropriate level of investigation for a complaint concerning quality of care, including:

(i) A determination as to whether the member or subscriber with the complaint previously attempted to have the complaint resolved; and

(ii) A determination as to whether a complaint should be sent to the member's or subscriber's health maintenance organization for resolution prior to investigation under the provisions of this section; and

(3) A procedure for the referral OF QUALITY OF CARE COMPLAINTS to the [Commissioner] SECRETARY [of all complaints, other than quality of care complaints,] for an appropriate investigation.

(c) If a determination is made to investigate a complaint under the provisions of this section prior to the member or subscriber attempting to otherwise resolve the complaint, the reasons for that determination shall be documented.

(d) Notice of the complaint system established under the provisions of this section shall be included in all contracts between a health maintenance organization and a member or subscriber of a health maintenance organization.

(E) FOR QUALITY OF CARE COMPLAINTS REFERRED TO THE SECRETARY FOR INVESTIGATION UNDER SUBSECTION (B)(3) OF THIS SECTION, THE SECRETARY SHALL REPORT TO THE COMMISSIONER IN A TIMELY MANNER ON THE RESULTS AND FINDINGS OF EACH INVESTIGATION.".

AMENDMENT NO. 7

On page 59, before line 15 insert:

"19-1502.

(a) There is a Maryland Health Care Access and Cost 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 Resources Planning Commission and the Health Services Cost Review Commission;

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

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

(4) 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;

(5) 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;

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

(7) 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;

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

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

[(10)] (9) Foster the development of practice parameters;

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

[(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

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

AMENDMENT NO. 8

On page 59, in line 15, strike "19-148." and substitute "19-1507."; in line 29, strike "and"; and in line 31, after the semicolon insert "AND

(VIII) IF THE PROVIDER RENDERING THE SERVICE IS A CERTIFIED REGISTERED NURSE ANESTHETIST OR A CERTIFIED NURSE MIDWIFE, THE IDENTIFICATION MODIFIER FOR THE CERTIFIED REGISTERED NURSE ANESTHETIST OR CERTIFIED NURSE MIDWIFE;".

AMENDMENT NO. 9

On pages 60 through 76, strike in their entirety the lines beginning with line 5 on page 60 through line 11 on page 76 and substitute:

"19-1509.

(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]:

(1) PROHIBIT the unbundling of codes and the use of reimbursement maximization programs, commonly known as "upcoding"; AND

(2) REQUIRE PAYORS TO:

(I) USE REBUNDLING EDITS; AND

(II) MAKE THE STANDARDS FOR REBUNDLING AVAILABLE TO THE PUBLIC ON REQUEST.

[(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)] (C) (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 (1) of this subsection, the Commission may publish any other information that the Commission deems appropriate, INCLUDING INFORMATION ON CAPITATED HEALTH CARE SERVICES.

[(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 Maryland Hospital Association, 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 this 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.]

19-1606.

(a) On receipt of a proposal of the Advisory Committee concerning adoption of any practice parameters, by regulation, the Commission may adopt the practice parameters.

(b) The Commission may adopt a practice parameter if:

(1) The proposal of the Advisory Committee includes a statement, with supporting documentation, that at least 60 percent of the VOTES CAST BY specialists in the State affected by the practice parameter [have voted favorably on the] FAVOR adoption;

(2) The proposal of the Advisory Committee includes supporting information satisfactory to the Commission that the practice parameter will reduce unnecessary utilization of health care services; and

(3) The proposal of the Advisory Committee includes supporting information satisfactory to the Commission that the practice parameter will continue to provide a high quality of health care.

(c) Any practice parameter adopted by the Commission shall remain in effect, by regulation no longer than 3 years from the date of its adoption. The Commission may readopt a practice parameter after its expiration following consultation with the appropriate medical [speciality] SPECIALTY.

(d) The Advisory Committee may submit amendments to a practice parameter for adoption by the Commission at any time.

(e) A practice parameter adopted under this subtitle is not admissible into evidence in any legal proceeding in this State as evidence of a standard of care.".

AMENDMENT NO. 10

On page 76, before line 12 insert "Article - Insurance".

AMENDMENT NO. 11

On page 86, after line 8, insert:

"15-1003.

(c) (1) The Commissioner shall adopt by regulation a uniform claims form for reimbursement of health care practitioners' services.

(2) IF THE HEALTH CARE PRACTITIONER RENDERING THE SERVICE IS A CERTIFIED REGISTERED NURSE ANESTHETIST OR A CERTIFIED NURSE MIDWIFE, THE UNIFORM CLAIMS FORM SHALL INCLUDE THE IDENTIFICATION MODIFIER FOR THE CERTIFIED REGISTERED NURSE ANESTHETIST OR CERTIFIED NURSE MIDWIFE.".

On pages 86 through 96, strike in their entirety the lines beginning with line 9 on page 86 through line 38 on page 96.

AMENDMENT NO. 12

On page 96, before line 39 insert:

"SECTION 3. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene, in consultation with the Health Resources Planning Commission, Health Services Cost Review Commission, and Health Care Access and Cost Commission, shall:

(a) conduct a comprehensive study of the certificate of need program to determine:

(1) the necessity of requiring a certificate of need for:

(i) building, developing, or establishing a health care facility;

(ii) moving a health care facility to another site;

(iii) changing the bed capacity of a health care facility;

(iv) changing the type or scope of any health care service, including in particular a home health program, a hospice program, or a specialty medical program;

(v) making a certain capital expenditure; and

(vi) closing a hospital or part of a hospital, particularly in a single-hospital

jurisdiction; and

(2) the possibility of further consolidating, modifying, or streamlining the certificate of need application process in those situations that the Department, in consultation with the Commissions, determines a certificate of need is necessary; and

(b) on or before January 1, 1999, submit a report of its study, including recommendations, to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

SECTION 4. AND BE IT FURTHER ENACTED, That:

(a) the survey by the Health Resources Planning Commission of freestanding ambulatory surgery utilization, capacity, and financial data shall be conducted annually in a manner that assures comparability with data collected by the Health Services Cost Review Commission;

(b) the data collected by the Health Services Cost Review Commission concerning ambulatory surgery shall be done in a manner that permits comparison of costs, charges, uncompensated care, and other pertinent data deemed necessary;

(c) data collected by the Health Resources Planning Commission and the Health Services Cost Review Commission shall permit comparability of the hospital and freestanding ambulatory surgery settings; and

(d) the Commissions shall consult with interested parties in the Commissions' data collection design.

SECTION 5. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission shall:

(a) study the issue of financing the cost of uncompensated care for the types of procedures and services performed or provided by freestanding ambulatory care facilities;

(b) include in its study the feasibility and desirability of establishing a method and

mechanism to finance the reasonable cost of uncompensated care through an assessment on freestanding ambulatory care facilities;

(c) take into consideration a financing policy that:

(1) promotes access to medically necessary outpatient services for individuals without health insurance;

(2) equitably distributes the reasonable costs of uncompensated care;

(3) fairly determines the costs of reasonable uncompensated care included in the charges for procedures or services performed or provided by freestanding ambulatory care facilities; and

(4) will provide incentives for efficient and effective credit and collection policies; and

(d) make recommendations regarding the financing of uncompensated care costs by January 1, 1999 to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

SECTION 6. AND BE IT FURTHER ENACTED, That:

(a) The Insurance Commissioner and the Executive Director of the Health Care Access and Cost Commission shall establish a small group insurance market coordinating task force comprised of senior staff members of the two agencies.

(b) The task force shall:

(1) meet quarterly to discuss and report on issues of common concern and coordination; and

(2) establish a formal protocol for resolving questions of interpretation of the small group insurance market legislation and regulations.

(c) The Commissioner shall:

(1) provide a liaison to attend Commission meetings; and

(2) consult in a timely manner with the Executive Director with respect to issues raised in the small group insurance market filings.

SECTION 7. AND BE IT FURTHER ENACTED, That:

(a) The Insurance Commissioner and the Executive Directors of the Health Services Cost Review Commission and the Health Care Access and Cost Commission shall establish an interagency task force comprised of senior staff members of the three agencies to coordinate the analysis of downstream risk arrangements between licensed carriers and subcontracting provider entities.

(b) The interagency task force shall conduct a study of the extent and nature of downstream risk arrangements in Maryland and report its findings and recommendations to the three agencies, the Senate Finance Committee, the House Economic Matters Committee, and the House Environmental Matters Committee by December 1, 1999.

(c) As part of the study, the task force shall consider recommendations from the affected industries.

SECTION 8. AND BE IT FURTHER ENACTED, That:

(a) The Health Care Access and Cost Commission shall study the feasibility of establishing and implementing a system to comparatively evaluate the quality of care outcomes and performance measurements of hospitals and other health care providers on an objective basis.

(b) In conducting the study, the Commission shall assume that the purpose of the comparative performance measurement system is to improve the quality of care by establishing a common set of performance measurements and disseminating the findings.

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(c) As part of the study, the Commission shall consider recommendations from hospitals, other health care providers, and other interested parties.

(d) The Commission shall also consider in its study existing outcome and performance measurement systems for hospitals and other health care providers as well as the availability of existing data.

(e) The Commission shall report its findings and recommendations from the study to the Senate Finance Committee, the House Economic Matters Committee, and the House Environmental Matters Committee by December 1, 1998.

SECTION 9. AND BE IT FURTHER ENACTED, That:

(a) Due to the rapid changes the health care market is experiencing, the Health Care Access and Cost Commission shall study and make recommendations on the findings that result from a study on the desirability of continuing to develop practice parameters for health care practitioners.

(b) The study shall include an evaluation of:

(1) the goals of practice parameter development;

(2) the appropriateness of the practice parameters authorized in Title 19, Subtitle 16 of the Health - General Article to achieving these goals;

(3) the feasibility and desirability of enhancing the use of practice parameters in utilization review decisions and malpractice cases; and

(4) any other factors the Commission regards as important.

(c) The Health Care Access and Cost Commission shall report its findings and recommendations to the Senate Finance Committee, the House Economic Matters Committee, and the House Environmental Matters Committee on or before November 1, 1998.

SECTION 10. AND BE IT FURTHER ENACTED, That:

(a) The Department of Health and Mental Hygiene, in consultation with the Health Resources Planning Commission, shall study and develop a methodology for calculating hospital licensed bed capacity that more accurately reflects actual licensed and staffed and operated beds.

(b) The methodology shall address:

(1) occupancy variations by service throughout the year;

(2) migration patterns and current and future projected population data;

(3) accessibility and availability of beds;

(4) patient stays of less than 24 hours; and

(5) managed care contracting arrangements with hospitals.

(c) On or before January 1, 1999, the Department shall submit a report of its study, including any recommendations, to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

(d) The Department, in consultation with the Commission, shall adopt regulations to implement the methodology developed under this section on or before July 1, 1999.

SECTION 11. AND BE IT FURTHER ENACTED, That, notwithstanding the provisions of § 19-105 of the Health - General Article prohibiting the participation of the Secretary or the Secretary's designee in the considerations of the Health Resources Planning Commission concerning personnel matters involving Commission staff, the Secretary, in consultation with the Commission, may transfer to the Department of Health and Mental Hygiene Commission staff necessary to develop the State health plan.

SECTION 12. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission may implement the changes to § 19-217

of the Health - General Article, as enacted by Section 2 of this Act, relating to the regulation of hospital outpatient surgical services, in only one region of the State in 1998.

(b) Prior to implementing the changes in other regions of the State, the Commission shall report to the Senate Finance Committee, the House Environmental Matters Committee, and the House Economic Matters Committee on the effect of these changes on:

(1) regulated hospital rates;

(2) the cost of outpatient surgery to consumers and payers;

(3) access to outpatient surgery, particularly for individuals without health insurance; and

(4) the State's Medicare waiver.

(c) It is the intent of the General Assembly that, in reviewing and approving hospital regulated rates, the Commission only take into account the costs attributable to regulated hospital services and exclude costs attributable to unregulated hospital services, including, where applicable, outpatient surgical services.

(d) The changes to § 19-217 of the Health - General Article, as enacted by Section 2 of this Act, shall remain effective for a period of 1 year and 6 months and, at the end of December 31, 1999, with no further action required by the General Assembly, the changes made by Section 2 of this Act to § 19-217 of the Health - General Article shall be null and void.";

and in line 39, strike "14." and substitute "13.".