Unofficial Copy **1998 Regular Session**
HB0002/103273/2

BY: Environmental Matters Committee and Economic Matters Committee

AMENDMENTS TO HOUSE BILL NO. 2
(First Reading File Bill, Second Printing)

AMENDMENT NO. 1

On page 1, in the sponsor line, strike "and Workman" and substitute "Workman, Boston, DeCarlo, Donoghue, Eckardt, Exum, Fulton, Gordon, Kirk, McHale, Miller, Mohorovic, and Valderrama".

AMENDMENT NO. 2

On page 1, in lines 4 and 5, strike "Maryland Health Care Access and Cost Commission" and substitute "Maryland Health Regulatory Commission"; in line 7, after "Commission;" insert "providing for the initial appointment of the members of the Commission;"; in line 8, strike "Health Care Access and Cost Commission" and substitute "Health Regulatory Commission"; in line 9, after "to" insert "State"; strike beginning with "repealing" in line 10 down through "circumstances;" in line 12 and substitute "repealing certain requirements for certain health care facilities to obtain a certificate of need or exemption from a certificate of need when changing the type or scope of health care services and reallocation of existing bed capacity under certain circumstances;"; strike beginning with "authorizing" in line 12 down through "circumstances;" in line 15; in line 15, strike "altering" and substitute "repealing"; in line 17, strike "by the Commission"; strike beginning with "transferring" in line 18 down through "Commission;" in line 22 and substitute "requiring the Department of Health and Mental Hygiene to ensure that certain discharge data be submitted by certain persons under certain circumstances; requiring the Department of Health and Mental Hygiene to conduct certain studies; establishing the classification of "limited service hospital" for certain health care facilities; specifying that a certificate of need is not required for the conversion of a hospital to a limited service hospital; providing a certain exception;"; and in line 23, strike "Commission" and substitute "Maryland Health Care Access and Cost Commission".

On page 2, in line 1, after "Act;" insert "providing for a delayed effective date"; in line 9, strike "19-1511," and substitute "19-1502 through 19-1506, 19-1509 through"; in line 28, strike "19-1502 through 19-1506, 19-1510,"; in line 33, strike "19-103 through 19-107, 19-108"; and in

(Over)

line 36, strike "19-146, and 19-147" and substitute "and 19-146".

On pages 2 and 3, strike in their entirety the lines beginning with line 42 on page 2 through line 12 on page 3, inclusive.

On page 3, in line 31, after "Section" insert "15-103(b)(28);"; strike beginning with ", 19-102" in line 31 down through "Commission" in line 32 and substitute "through 19-111 to be under the new part "Part I. Maryland Health Regulatory Commission"; in line 33, strike "Care Planning and"; and in line 34, strike "19-134,".

On page 4, in line 1, strike "19-103"; in line 4, strike "19-151(b) and (c)" and substitute "19-151"; in line 10, strike "19-104, 19-105, 19-106, 19-107, 19-108,"; in line 18, before "19-404" insert "19-301, 19-307,"; in the same line, strike "19-705.1(f)(5), 19-705.2,"; in line 23, strike "and 15-1001"and substitute "15-1003(c)"; and strike in their entirety lines 26 through 34, inclusive.

On page 5, strike in their entirety lines 1 through 3, inclusive; in line 8, strike "19-1511," and substitute "19-1502 through 19-1506, 19-1509 through"; strike beginning with "19-1502" in line 14 down through "19-1510," in line 15; in lines 23 and 24, strike "19-146, and 19-147" and substitute "and 19-146"; strike in their entirety lines 27 through 33, inclusive; and in line 34, strike "4." and substitute "3.".

On page 47, in line 26, strike "19-135." and substitute "19-134.".

On page 48, in lines 1 and 21, strike "19-136." and "19-137.", respectively, and substitute "19-135." and "19-136.", respectively; and in lines 12 and 20, in each instance, strike "19-135" and substitute "19-134".

On page 49, in lines 5 and 22, strike "19-138." and "19-139.", respectively, and substitute "19-137." and "19-138.", respectively.

On page 50, in line 9, strike "19-140." and substitute "19-139."; and in line 21, strike "§ 19-142" and substitute "§ 19-141".

On page 51, in line 33, strike "19-141." and substitute "19-140.".

On page 52, in line 1, strike "19-142." and substitute "19-141."; and in line 3, strike "§ 19-140(B)" and substitute "§ 19-139(B)".

On page 53, in line 24, strike "19-140" and substitute "19-139".

On page 54, in lines 1 and 8, strike "19-143." and "19-144.", respectively, and substitute "19-142." and "19-143.", respectively.

On page 55, in lines 1, 10, and 23, strike "19-145.", "19-146.", and "19-147.", respectively, and substitute "19-144.", "19-145.", and "19-146.", respectively.

AMENDMENT NO. 3

On page 7, in line 16, strike "HEALTH CARE ACCESS AND COST" and substitute "HEALTH REGULATORY".

On pages 8 through 11, strike in their entirety the lines beginning with line 7 on page 8 through line 27 on page 11, inclusive, and substitute:

"SUBTITLE 1. HEALTH SYSTEMS REGULATION.

PART I. MARYLAND HEALTH REGULATORY COMMISSION.

19-101.

IN THIS SUBTITLE "COMMISSION" MEANS THE MARYLAND HEALTH REGULATORY COMMISSION.

19-102.

(A) THE GENERAL ASSEMBLY FINDS THAT THE HEALTH CARE REGULATORY SYSTEM IN THIS STATE IS A HIGHLY COMPLEX STRUCTURE THAT NEEDS TO BE CONSTANTLY REEVALUATED AND MODIFIED IN ORDER TO BETTER REFLECT AND BE MORE RESPONSIVE TO THE EVER CHANGING HEALTH CARE ENVIRONMENT AND THE NEEDS OF THE RESIDENTS OF THIS STATE.

(B) THE PURPOSE OF THIS SUBTITLE IS TO ESTABLISH A STREAMLINED HEALTH CARE REGULATORY SYSTEM IN THIS STATE IN A MANNER SUCH THAT A

SINGLE STATE HEALTH REGULATORY POLICY CAN BE BETTER ARTICULATED, COORDINATED, AND IMPLEMENTED IN ORDER TO BETTER SERVE THE RESIDENTS OF THIS STATE.

19-103.

(A) THERE IS A MARYLAND HEALTH REGULATORY 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 OF HEALTH CARE SERVICES FOR ALL MARYLANDERS;

(2) PROMOTE THE DEVELOPMENT OF A HEALTH REGULATORY SYSTEM THAT PROVIDES, FOR ALL MARYLANDERS, FINANCIAL AND GEOGRAPHIC ACCESS TO QUALITY HEALTH CARE 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) 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;

(8) ESTABLISH STANDARDS FOR THE OPERATION AND LICENSING OF MEDICAL CARE ELECTRONIC CLAIMS CLEARINGHOUSES IN THE STATE;

(9) PROMOTE THE AVAILABILITY OF INFORMATION TO CONSUMERS ON CHARGES AND REIMBURSEMENTS IN ADVANCE OF RECEIVING HEALTH CARE SERVICES; AND

(10) REDUCE THE COSTS OF CLAIMS SUBMISSION AND THE ADMINISTRATION OF CLAIMS FOR HEALTH CARE PRACTITIONERS AND PAYORS.

19-104.

(A) THE COMMISSION SHALL CONSIST OF 9 MEMBERS APPOINTED BY THE GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE.

(B) (1) OF THE 9 MEMBERS:

(I) ONE EACH SHALL BE APPOINTED FROM THIRD PARTY PAYORS, HEALTH CARE PRACTITIONERS, THE LONG-TERM CARE INDUSTRY, HOSPITALS, AND THE ACADEMIC COMMUNITY;

(II) TWO SHALL BE APPOINTED FROM THE BUSINESS COMMUNITY; AND

(III) TWO SHALL BE MEMBERS OF THE GENERAL PUBLIC .

(2) FOUR OF THE MEMBERS APPOINTED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE INDIVIDUALS WHO DO NOT HAVE ANY CONNECTION WITH THE MANAGEMENT OR POLICY OF A HEALTH CARE PROVIDER OR THIRD PARTY PAYOR.

(C) TO THE EXTENT PRACTICABLE, WHEN APPOINTING MEMBERS TO THE COMMISSION THE GOVERNOR SHALL ENSURE GEOGRAPHIC BALANCE IN THE COMMISSION'S MEMBERSHIP.

(D) (1) THE TERM OF A MEMBER IS 4 YEARS.

(2) THE TERMS OF THE MEMBERS ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS OF THE COMMISSION ON JANUARY 1, 1999.

(3) A MEMBER WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES ONLY FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(4) THE GOVERNOR MAY REMOVE A MEMBER FOR NEGLECT OF DUTY, INCOMPETENCE, OR MISCONDUCT.

(5) A MEMBER MAY NOT SERVE MORE THAN TWO CONSECUTIVE TERMS.
19-105.

(A) THE GOVERNOR SHALL APPOINT THE CHAIRMAN OF THE COMMISSION.

(B) THE CHAIRMAN MAY APPOINT A VICE CHAIRMAN.

19-106.

(A) THE COMMISSION SHALL APPOINT AN EXECUTIVE DIRECTOR WHO SHALL BE THE CHIEF ADMINISTRATIVE OFFICER OF THE COMMISSION.

(B) THE EXECUTIVE DIRECTOR SHALL:

(1) POSSESS A BROAD KNOWLEDGE OF GENERALLY ACCEPTED PRACTICES IN THE DELIVERY OF HEALTH CARE SERVICES AND THE FINANCING OF HEALTH CARE IN THE STATE; AND

(2) BE REASONABLY WELL INFORMED OF THE GENERAL LAWS AND REGULATIONS THAT GOVERN ALL FACETS OF THE DELIVERY AND FINANCING OF HEALTH CARE.

(C) (1) THE EXECUTIVE DIRECTOR SHALL DEVOTE FULL TIME TO THE DUTIES OF THE OFFICE.

(2) THE EXECUTIVE DIRECTOR MAY NOT HOLD ANY POSITION OR ENGAGE IN ANOTHER BUSINESS THAT:

(I) INTERFERES WITH THE POSITION OF EXECUTIVE DIRECTOR; OR

(II) MIGHT CONFLICT OR HAVE THE APPEARANCE OF CONFLICTING WITH THE POSITION OF EXECUTIVE DIRECTOR.

(D) THE EXECUTIVE DIRECTOR AND ANY DEPUTY DIRECTORS AND PRINCIPAL SECTION CHIEFS SERVE AT THE PLEASURE OF THE COMMISSION.

(E) THE COMMISSION, IN CONSULTATION WITH THE SECRETARY, SHALL DETERMINE THE APPROPRIATE JOB CLASSIFICATION AND, SUBJECT TO THE STATE BUDGET, THE COMPENSATION OF THE EXECUTIVE DIRECTOR, THE DEPUTY DIRECTORS, AND THE PRINCIPAL SECTION CHIEFS.

(F) UNDER THE DIRECTION OF THE COMMISSION, THE EXECUTIVE DIRECTOR SHALL PERFORM ANY DUTY OR FUNCTION THAT THE COMMISSION REQUIRES.

19-107.

(A) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A MAJORITY OF THE FULL AUTHORIZED MEMBERSHIP OF THE COMMISSION IS A QUORUM.

(2) THE COMMISSION MAY NOT ACT ON ANY MATTER UNLESS AT LEAST FOUR OF THE VOTING MEMBER OF THE COMMISSION IN ATTENDANCE CONCUR.

(B) THE COMMISSION SHALL MEET AT THE TIMES AND PLACES THAT IT DETERMINES ARE APPROPRIATE.

(C) EACH MEMBER OF THE COMMISSION IS ENTITLED TO:

(1) COMPENSATION IN ACCORDANCE WITH THE STATE BUDGET; AND

(2) REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

(D) THE COMMISSION MAY EMPLOY A STAFF IN ACCORDANCE WITH THE STATE BUDGET.".

On page 11, in line 28, strike "19-109." and substitute "19-108.".

On page 12, in line 23, in each instance, strike "JULY" and substitute "DECEMBER".

On page 13, after line 9, insert:

"19-109.

(A) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS SUBTITLE, THE COMMISSION SHALL ADOPT REGULATIONS SPECIFYING THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN TO APPLY UNDER TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE.

(B) IN CARRYING OUT ITS DUTIES UNDER THIS SECTION, THE COMMISSION SHALL COMPLY WITH THE PROVISIONS OF § 15-1207 OF THE INSURANCE ARTICLE.";

and in line 23, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "HEALTH REGULATORY COMMISSION".

AMENDMENT NO. 4

On page 8, after line 6, insert:

"15-103.

(28) (I) THE DEPARTMENT SHALL ENSURE THAT PAYMENTS FOR SERVICES PROVIDED BY A HOSPITAL OR A FREESTANDING AMBULATORY CARE FACILITY LOCATED IN A CONTIGUOUS STATE OR IN THE DISTRICT OF COLUMBIA TO AN ENROLLEE UNDER THE PROGRAM SHALL BE REDUCED BY 20 PERCENT IF THE HOSPITAL OR FREESTANDING AMBULATORY CARE FACILITY FAILS TO SUBMIT DISCHARGE DATA ON ALL MARYLAND PATIENTS RECEIVING CARE IN THE HOSPITAL OR FREESTANDING AMBULATORY CARE FACILITY TO THE HEALTH SERVICES COST REVIEW COMMISSION IN A FORM AND MANNER THE COMMISSION SPECIFIES.

(II) SUBPARAGRAPH (I) OF THIS PARAGRAPH WILL NOT APPLY TO A HOSPITAL OR A FREESTANDING AMBULATORY CARE FACILITY THAT PRESENTLY PROVIDES DISCHARGE DATA TO THE PUBLIC IN A SUFFICIENT FORM.".

AMENDMENT NO. 5

On page 14, in line 10, strike "$11,000,000" and substitute "$10,000,000"; in line 14, after "SUBTITLE" insert ", INCLUDING THE ACTUAL DOCUMENTED DIRECT AND INDIRECT COSTS TO THE COMMISSION OF CARRYING OUT ITS RESPONSIBILITIES RELATED TO THOSE HEALTH PLANNING FUNCTIONS THAT ARE DELEGATED TO THE COMMISSION BY THE DEPARTMENT UNDER § 19-119 OF THIS SUBTITLE"; in line 24, strike "$5,500,000 IN ANY FISCAL YEAR" and substitute "54% OF THE MAXIMUM AMOUNT THAT MAY BE ASSESSED IN ANY FISCAL YEAR, AS PROVIDED IN SUBSECTION (C)(1) OF THIS SECTION"; in line 26, strike "$1,500,000 IN ANY FISCAL YEAR" and substitute "3% OF THE MAXIMUM AMOUNT THAT MAY BE ASSESSED IN ANY FISCAL YEAR, AS PROVIDED IN SUBSECTION (C)(1) OF THIS SECTION"; in line 28, strike "$3,250,000 IN ANY FISCAL YEAR" and substitute "29% OF THE MAXIMUM AMOUNT THAT MAY BE ASSESSED IN ANY FISCAL YEAR, AS PROVIDED IN SUBSECTION (C)(1) OF THIS SECTION"; and in line 30, strike "$750,000 IN ANY FISCAL YEAR" and substitute "14% OF THE MAXIMUM AMOUNT THAT MAY BE ASSESSED IN ANY FISCAL YEAR, AS PROVIDED IN SUBSECTION (C)(1) OF THIS SECTION".

AMENDMENT NO. 6

On page 7, strike in their entirety lines 31 and 32, inclusive.

On page 8, in lines 1, 3, and 5, strike "(d)", "(e)", and "(f)", respectively, and substitute "(C)", "(D)", and "(E)", respectively.

On page 8, in line 5, strike "HEALTH CARE ACCESS AND COST Commission" and substitute "SECRETARY".

On page 18, in line 24, strike "Commission" and substitute "SECRETARY".

On page 19, in line 14, strike "COMMISSION" and substitute "SECRETARY".

On page 20, strike in their entirety lines 11 through 23, inclusive; and in lines 25, 29, 32, 34, and 35, in each instance, strike "Commission" and substitute "SECRETARY".

On page 21, in lines 2, 13, 27, and 29, in each instance, strike "Commission" and substitute

"SECRETARY"; and in line 34, strike "Commission" and substitute "DEPARTMENT".

On page 22, in line 17, strike "Commission" and substitute "SECRETARY".

On page 23, in lines 9, 22, 24, 25, 28, and 31, in each instance, strike "Commission" and substitute "SECRETARY"; in line 31, strike "include" and substitute "DEVELOP"; and in the same line, strike "in" and substitute "CONSISTENT WITH".

On page 24, in lines 4, 7, and 20, in each instance, strike "Commission" and substitute "SECRETARY"; in line 4, strike "may" and substitute "SHALL"; in line 5, before "USED" insert "OF THE COMMISSION"; in lines 7 and 8, in each instance, strike "Secretary" and substitute "COMMISSION"; in line 14, strike "its" and substitute "THEIR"; in line 15, after "Commission" insert "AND THE SECRETARY"; and after line 18, insert:

"(I) THE DEPARTMENT SHALL, IN CONSULTATION WITH THE COMMISSION, DELEGATE TO THE COMMISSION THE HEALTH PLANNING FUNCTIONS NECESSARY FOR THE COMMISSION TO CARRY OUT ITS RESPONSIBILITIES UNDER THIS PART II OF THIS SUBTITLE RELATED TO THE CERTIFICATE OF NEED PROGRAM.".

On page 25, in lines 5, 7, 11, and 16, in each instance, strike "Commission" and substitute "SECRETARY".

On page 27, in line 30, strike "Commission" and substitute "SECRETARY".

On page 28, in line 34, strike "Commission" and substitute "SECRETARY".

On page 33, in line 12, strike "Commission" and substitute "SECRETARY".

AMENDMENT NO. 7

On page 24, strike beginning with the colon in line 24 down through "1997" in line 30.

On page 26, in lines 31 and 34, in each instance, strike the brackets; and in lines 31 and 34, in each instance, strike "EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A".

(Over)

On page 27, in line 7, strike the brackets; in the same line, strike "EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A"; in line 12, strike "During" and substitute "FOR A HEALTH CARE FACILITY THAT IS NOT A HOSPITAL, DURING"; in line 20, strike "or"; in line 33, after "interest" insert ";OR

(IV) ON OR AFTER JULY 1, 1999, THE CHANGE IN BED CAPACITY IS A RESULT OF A REALLOCATION OF EXISTING BED CAPACITY BETWEEN HOSPITALS IN A MERGED ASSET ORGANIZATION LOCATED WITHIN THE SAME HEALTH SERVICE AREA THAT DOES NOT INVOLVE A HOSPITAL THAT IS A COMPONENT OF THE MERGED ASSET ORGANIZATION THAT IS THE SOLE PROVIDER OF MEDICAL SERVICES IN A COUNTY AND, AT LEAST 45 DAYS BEFORE THE PROPOSED REALLOCATION, NOTICE OF INTENT TO REALLOCATE BED CAPACITY IS FILED WITH THE COMMISSION.";

and in line 34, after "notice" insert "UNDER PARAGRAPH (2)(II) OR (III) OF THIS SUBSECTION".

On page 28, in line 1, strike the brackets; in the same line, strike "EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A"; in lines 19 and 20, in each instance, strike the bracket.

On page 29, in line 5, after "finding" insert "; OR

(V) ON OR AFTER JULY 1, 1999, THE PROPOSED CHANGE IN THE TYPE OR SCOPE OF A HEALTH CARE SERVICE BETWEEN A HOSPITAL AND 1 OR MORE OTHER HOSPITALS THAT ARE COMPONENTS OF A MERGED ASSET ORGANIZATION WITHIN THE SAME HEALTH SERVICE AREA AND A HOSPITAL INVOLVED IN THE PROPOSED CHANGE IS NOT THE SOLE PROVIDER IN A COUNTY OF THE HEALTH CARE SERVICE PROPOSED TO BE CHANGED AND, AT LEAST 45 DAYS BEFORE THE PROPOSED CHANGE, NOTICE OF THE CHANGE IS FILED WITH THE COMMISSION";

in lines 6 and 25, in each instance, strike the bracket; in line 26, strike the brackets; and in the same line, strike "EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A".

On page 33, in line 6, strike "A" and substitute:

"(1) FOR A CLOSURE OR PARTIAL CLOSURE OF A HOSPITAL THAT IS THE SOLE PROVIDER OF MEDICAL SERVICES IN A COUNTY, A";

in lines 8, 10, and 13, strike "(1)", "(2)", and "(3)", respectively, and substitute "(I)", "(II)", and "(III)", respectively; and after line 14, insert:

"(2) (I) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, A CERTIFICATE OF NEED OR AN EXEMPTION FROM HAVING TO OBTAIN A CERTIFICATE OF NEED, INCLUDING COMMISSION APPROVAL, IS NOT REQUIRED TO CLOSE ANY HOSPITAL OR PART OF A HOSPITAL AS DEFINED IN §19-301 OF THIS TITLE, INCLUDING A STATE HOSPITAL.

(II) AT LEAST 45 DAYS BEFORE THE CLOSING OR PARTIAL CLOSING, THE PERSON PROPOSING THE CLOSURE OR PARTIAL CLOSURE OF THE HOSPITAL SHALL FILE NOTICE OF THE PROPOSED CLOSING OR PARTIAL CLOSING WITH THE COMMISSION.

(III) IN ADDITION TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE PERSON PROPOSING THE CLOSURE OR PARTIAL CLOSURE OF THE HOSPITAL SHALL HOLD A PUBLIC INFORMATIONAL MEETING IN THE COUNTY WHERE THE HOSPITAL IS LOCATED.".

On page 34, strike in their entirety lines 3 through 7, inclusive.

AMENDMENT NO. 8

On page 25, after line 28, insert:

"(3) "LIMITED SERVICE HOSPITAL" MEANS A HEALTH CARE FACILITY THAT:

(I) IS LICENSED AS A HOSPITAL ON OR AFTER JANUARY 1, 1998; AND

(II) CHANGES THE TYPE OR SCOPE OF HEALTH CARE SERVICES OFFERED BY ELIMINATING THE FACILITY'S CAPABILITY TO ADMIT OR RETAIN PATIENT'S FOR OVERNIGHT ACUTE MEDICAL-SURGICAL CARE.";

and in line 29, strike "(3)" and substitute "(4)".

On page 28, in line 31, strike the first "or" and substitute "THE"; and in line 32, after "use" insert ", OR THE CONVERSION OF A HOSPITAL TO A LIMITED SERVICE HOSPITAL".

On page 29, in line 2, strike "and"; after line 2, insert:

"D. FOR A PROPOSED CONVERSION OF A HOSPITAL TO A LIMITED SERVICE HOSPITAL, THE HOSPITAL BEING PROPOSED FOR CONVERSION IS NOT THE SOLE PROVIDER OF MEDICAL SERVICES IN A COUNTY; AND";

and in line 3, strike "D." and substitute "E.".

On page 63, after line 23, insert:

"Subtitle 3. Hospitals and Related Institutions.

19-301.

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

(b) "Accredited hospital" means a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

(c) "Accredited residential treatment center" means a residential treatment center that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

(d) "Apartment unit" means any space, in a residential building, that is enclosed and self-contained and has a sanitary environment, if the space includes:

(1) 2 or more rooms;

(2) A direct exit to a thoroughfare or to a common element leading to a thoroughfare;

(3) Facilities for living, sleeping, and eating; and

(4) At least the following facilities for cooking:

(i) Storage space for food and utensils;

(ii) A refrigerator;

(iii) A cook top; and

(iv) Adequate electrical capacity and outlets for small appliances.

(e) (1) "Domiciliary care" means services that are provided to aged or disabled individuals in a protective, institutional or home-type environment.

(2) "Domiciliary care" includes:

(i) Shelter;

(ii) Housekeeping services;
(iii) Board;

(iv) Facilities and resources for daily living; and

(v) Personal surveillance or direction in the activities of daily living.

(f) "Hospital" means an institution that:

(1) Has a group of at least 5 physicians who are organized as a medical staff for the institution;

(2) Maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for 2 or more unrelated individuals; and

(3) Admits or retains the individuals for overnight care.

(g) "License" means a license issued by the Secretary:

(1) To operate a hospital OR LIMITED SERVICE HOSPITAL in this State;

(2) To operate a related institution in this State; or

(3) To operate a residential treatment center in this State.

(H) "LIMITED SERVICE HOSPITAL" MEANS A HEALTH CARE FACILITY THAT:

(1) IS LICENSED AS A HOSPITAL ON OR AFTER JANUARY 1, 1998; AND

(2) CHANGES THE TYPE OR SCOPE OF HEALTH CARE SERVICES OFFERED BY ELIMINATING THE FACILITY'S CAPABILITY TO ADMIT OR RETAIN PATIENTS FOR OVERNIGHT ACUTE MEDICAL-SURGICAL CARE.

[(h)] (I) "Nonaccredited hospital" means a hospital not accredited by the Joint Commission on Accreditation of Healthcare Organizations.

[(i)] (J) "Nonaccredited residential treatment center" means a residential treatment center that is not accredited by the Joint Commission on Accreditation of Healthcare Organizations.

[(j)] (K) "Nursing care" means service for a patient that is:

(1) Ordered by a physician; and

(2) Provided or supervised by a registered or practical nurse who is licensed to practice in this State.

[(k)] (L) "Nursing facility" means a related institution that provides nursing care for 2 or more unrelated individuals.

[(l)] (M) "Person" includes this State or a county or municipal corporation.

[(m)] (N) (1) "Personal care" means a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation.

(2) "Personal care" includes:

(i) Help in walking;

(ii) Help in getting in and out of bed;

(iii) Help in bathing;

(iv) Help in dressing;

(v) Help in feeding; and

(vi) General supervision and help in daily living.

[(n)] (O) (1) "Related institution" means an organized institution, environment, or home that:

(i) Maintains conditions or facilities and equipment to provide domiciliary, personal, or nursing care for 2 or more unrelated individuals who are dependent on the

administrator, operator, or proprietor for nursing care or the subsistence of daily living in a safe, sanitary, and healthful environment; and

(ii) Admits or retains the individuals for overnight care.

(2) "Related institution" does not include a nursing facility or visiting nurse service that is conducted only by or for adherents of a bona fide church or religious organization, in accordance with tenets and practices that include reliance on treatment by spiritual means alone for healing.

[(o)] (P) "Residential treatment center" means a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting.

[(p)] (Q) "Unrelated individual" means anyone who is not:

(1) A child, grandchild, parent, grandparent, sibling, stepparent, stepchild, or spouse of the proprietor; or

(2) An in-law of any of these individuals.

19-307.

(a) (1) A hospital shall be classified:

(i) As a general hospital if the hospital at least has the facilities and provides the services that are necessary for the general medical and surgical care of patients;

(ii) As a special hospital if the hospital:

1. Defines a program of specialized services, such as obstetrics, mental health, tuberculosis, orthopedy, chronic disease, or communicable disease;

2. Admits only patients with medical or surgical needs within the program; and

3. Has the facilities for and provides those specialized services; [or]

(iii) As a special rehabilitation hospital if the hospital meets the requirements of this subtitle and Subtitle 12 of this title; OR

(IV) AS A LIMITED SERVICE HOSPITAL IF THE HOSPITAL:

1. IS LICENSED AS A HOSPITAL ON OR AFTER JANUARY 1, 1998; AND

2. CHANGES THE TYPE OR SCOPE OF HEALTH CARE SERVICES OFFERED BY ELIMINATING THE HOSPITAL'S CAPABILITY TO ADMIT OR RETAIN PATIENTS FOR OVERNIGHT ACUTE MEDICAL-SURGICAL CARE.

(2) The Secretary may set, by rule or regulation, other reasonable classifications for hospitals.

(b) A related institution shall be classified:

(1) As a care home if the related institution provides care to individuals who, because of advanced age or physical or mental disability, require domiciliary care or personal care in a protective environment; or

(2) As a nursing home if the related institution:

(i) Provides nursing care for chronically ill or convalescent patients; or

(ii) Offers to provide 24-hour a day nursing care of patients in a home-type facility such as:

1. A convalescent home;

2. A nursing unit of a home for the aged;

3. A psychiatric nursing home;

4. A nursing facility for the handicapped;

5. A home for alcoholics; or

6. A halfway house.".

AMENDMENT NO. 9

On pages 43 through 47, strike in their entirety the lines beginning with line 8 on page 43 through line 25 on page 47, inclusive.

AMENDMENT NO. 10

On page 50, in line 20, strike "(1)".

On pages 50 and 51, strike in their entirety the lines beginning with line 23 on page 50 through line 8 on page 51, inclusive.

AMENDMENT NO. 11

On pages 61 and 62, strike in their entirety lines beginning with line 1 on page 61 through line 29 on page 62, inclusive, and substitute:

"19-151.

(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;

(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.]".

AMENDMENT NO. 12

On pages 66 and 67, strike in their entirety the lines beginning with line 1 on page 66 through line 26 on page 67, inclusive.

AMENDMENT NO. 13

On pages 69 through 79, strike in their entirety the lines beginning with line 28 on page 69 through line 20 on page 79, inclusive, and substitute:

"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.".

AMENDMENT NO. 14

On page 68, in lines 22 and 23, strike "Maryland Health Care Access and Cost Commission" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 69, in lines 16 and 17, strike "Maryland Health Care Access and Cost Commission" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in line 19, strike "Health Care Access and Cost Fund" and substitute "HEALTH REGULATORY COMMISSION"; and in lines 22 and 23, strike "Maryland Health Care Access and Cost Commission" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 79, in lines 25 and 26, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 81, in lines 4 and 5, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; strike beginning with "Health" in line 7 down through "COMMISSION" in line 8 and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 16 and 17, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in line 21, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 26 and 27, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; and in lines 33 and 34, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 82, in lines 8 and 13, in each instance, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 17 and 18, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 20 and 21, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; and in line 26, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 83, in lines 3 and 15, in each instance, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 9 and 10, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 22 and 23 and lines 28 and 29, in each instance, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; strike beginning with "Upon" in line 33 down through "the" in line 34 and substitute "THE"; and in line 37, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 84, in lines 4 and 8, in each instance, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 25 and 26, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; and in line 27, strike "§ 19-143" and substitute "§ 19-142".

On page 85, in lines 8 and 9 and lines 22 and 23, in each instance, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 86, in lines 6 and 7 and lines 17 and 18, in each instance, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION"; in lines 12 and 26, in each instance, strike "HEALTH CARE ACCESS AND COST COMMISSION" and substitute "MARYLAND HEALTH REGULATORY COMMISSION".

On page 86, strike in their entirety lines 28 through 38, inclusive.

AMENDMENT NO. 15

On page 87, in lines 1 and 16, strike "5." and "6.", respectively, and substitute "4." and "7.", respectively; in lines 1 and 2, strike "Health Care Access and Cost Commission" and substitute "Maryland Health Regulatory Commission"; in line 4, after "for" insert "health care facility mergers and consolidations,"; in line 5, before "medical" insert "specialized"; in line 6, after "need" insert "or an exemption from having to obtain a certificate of need"; strike in their entirety lines 7 through 9, inclusive, and substitute:

"(2) whether there are alternative means of regulating specialized medical services other than a certificate of need program;";

in line 13, strike "December 1, 1998" and substitute "October 1, 1999"; after line 15, insert:

"SECTION 5. AND BE IT FURTHER ENACTED, That, notwithstanding any other provision of the Health - General Article:

(a) the capacity of each existing cardiac surgery program shall be defined, for the purposes of a review of an application for certificate of need for a cardiac surgery program for adults, as:

(1) the greater of 350 cases per hospital or the highest actual annual volume attained by the hospital in calendar year 1995 or calendar year 1996; or

(2) if a hospital has not performed, for the past three consecutive years, at least 200 cases per year, the capacity of that program is measured by the actual volume of cases performed in the hospital in calendar year 1996;

(b) The provisions of subsection (a) of this section will apply until October 1, 1999 or until the Health Regulatory Commission adopts a new standard for obtaining a certificate of need for a cardiac surgery program after the Commission reviews the standard and holds a public hearing on the appropriateness of altering the standard for obtaining a certificate of need for a cardiac surgery program.

(Over)

(c) When the Health Regulatory Commission adopts the standard under subsection (b) of this section, the Commission shall send notice to the Department of Legislative Services, 90 State Circle, Annapolis, Maryland 21401, that the contingency has been satisfied.

SECTION 6. AND BE IT FURTHER ENACTED, That:

(a) the Department of Health and Mental Hygiene, in consultation with the Health Resources Planning Commission, shall conduct a study on the impact that eliminating the requirement to obtain a certificate of need or an exemption from certificate of need to establish or expand a home health agency or hospice facility would have on the health care industry; and

(b) On or before December 1, 1998, the Department of Health and Mental Hygiene and the Health Resources Planning Commission shall submit a report to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.";

in line 17, strike "September" and substitute "July"; in line 19, strike "Maryland Health Care Access and Cost Commission's" and substitute "Maryland Health Regulatory Commission's proposed"; in lines 21 and 22, strike "Maryland Health Care Access and Cost Commission" and substitute "Maryland Health Regulatory Commission"; in line 24, strike "January 1, 1999"and substitute "December 1, 1998"; after line 26, insert:

"SECTION 8. AND BE IT FURTHER ENACTED, That:

(a) Due to the rapid changes the health care market is experiencing, the Health Care Assess and Cost Commission shall study practice parameters and their uses in the private health insurance market.

(b) The study shall include an evaluation of:

(i) the goals of practice parameters;

(ii) the use of practice parameters in utilization review decisions and malpractice cases; and

(iii) any other factors the Commission considers important.

(c) On or before December 1, 1998, the Health Care Access and Cost Commission shall submit a report on its findings and recommendations to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

SECTION 9. AND BE IT FURTHER ENACTED, That:

(a) The Department of Health and Mental Hygiene, in consultation with the Health Resources Planning Commission, the Health Services Cost Review Commission, and the Health Care Access and Cost Commission, shall:

(1) study and develop a methodology for calculating hospital licensed bed capacity that more accurately reflects for each hospital its actual licensed and staffed and operated beds;

(2) in developing the methodology, ensure that it addresses:

(i) occupancy variations by service throughout the year;

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

(iii) accessibility and availability of beds;

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

(v) managed care contracting arrangements with hospitals; and

(3) on or before January 1, 1999, submit a report of its study that includes the methodology developed and the number of licensed hospital beds subject to delicensure under the methodology, to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

(b) The Department of Health and Mental Hygiene, in consultation with the Health Resources

Planning Commission, the Health Services Cost Review Commission, and the Health Care Access and Cost Commission, shall:

(1) adopt by regulation the methodology developed by the Department; and

(2) before July 1, 1999, delicense any licensed hospital beds determined to be excess bed capacity under the methodology developed and adopted by the Department through regulation

SECTION 10. AND BE IT FURTHER ENACTED, That:

(a) The Insurance Commissioner, in consultation with the Health Services Cost Review Commission and the Health Care Access and Cost Commission, shall study downstream risk arrangements.

(b) The Insurance Commissioner shall:

(1) as part of the study, analyze downstream risk arrangements between licensed carriers and subcontracting providing entities and make recommendations as to whether changes to the current regulatory structure are needed to ensure consumers are protected against the consequences of an insolvency by entities, particularly health care provider organizations, that have accepted downstream risk;

(2) study the extent and nature of downstream risk arrangements in the State, including whether or not those assigned the downstream risk are aware of the implications of this assignment and the practice of carriers assigning the contracts of health care providers to other carriers; and

(3) on or before December 1, 1998, report its findings and recommendations to the Governor and, subject to § 2-1246 of the State Government Article, to the General Assembly.

SECTION 11. 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 this study, the Health Care Access and Cost 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 to the public.

(c) As part of this study, the Health Care Access and Cost Commission shall consider :

(1) recommendations from hospitals, other health care providers, and interested parties; and

(2) existing outcome and performance measurement systems for hospitals and other health care providers as well as the availability of existing data.

(d) On or before December 1, 1998, the Health Care Access and Cost Commission shall submit a report on its findings and any recommendations to the Governor and, subject to § 2-1246 of the State Government Article, to the General Assembly.";

before line 27, insert:

"SECTION 12. AND BE IT FURTHER ENACTED, That:

(a) On or before December 31, 1998, the Governor shall appoint members of the Maryland Health Regulatory Commission, as provided in § 19-104 of the Health - General Article, as enacted by this Act;

(b) For the first term of the Maryland Health Regulatory Commission only, the Governor shall appoint members to the Commission from among the current members of the Maryland Health Care Access and Cost Commission, the State Health Services Cost Review Commission, and the State Health Resources and Planning Commission, as those commissions exist before January 1, 1999, in the following manner:

(1) one representative each from third party payors, health care practitioners, the long-

term care industry, hospitals, and the academic community;

(2) two representatives from the business community; and

(3) two consumers;

(c) In appointing the Chairman of the Maryland Health Regulatory Commission, the Governor shall appoint the Chairman of the Health Care Access and Cost Commission, as that Commission existed before January 1, 1999, as the Chairman of the Maryland Health Regulatory Commission; and

(d) The terms of the initial members of the Maryland Health Regulatory Commission shall expire as follows:

(1) 3 members in 2003;

(2) 3 members in 2004;

(3) 2 members in 2005; and

(4) 1 member in 2006.";

in line 27, strike "7." and substitute "13."; in line 30, strike "and" and substitute a comma; in line 31, after "Commission" insert ", and the Maryland Health Care Access and Cost Commission"; in lines 31 and 32, strike "Maryland Health Care Access and Cost Commission" and substitute "Maryland Health Regulatory Commission"; in lines 34 and 36, in each instance, strike "July 1, 1998" and substitute "January 1, 1999"; in line 35, strike "or" and substitute a comma; in the same line, after "Commission," insert "or the Maryland Health Care Access and Cost Commission"; and in lines 37 and 38, strike "Maryland Health Care Access and Cost Commission" and substitute "Maryland Health Regulatory Commission".

AMENDMENT NO. 16

On page 88, in lines 2, 3, and 20, in each instance, strike "July 1, 1998" and substitute "January 1, 1999"; in lines 5, 10, 17, and 19, strike "8.", "9.", "10.", and "11.", respectively, and

substitute "14.", "15.", "20.", and "21.", respectively; in line 6, strike "Maryland Health Care Access and Cost Commission" and substitute "Maryland Health Regulatory Commission"; in line 7, strike "and" and substitute a comma; in line 8, after "Commission" insert ", and the Maryland Health Care Access and Cost Commission"; after line 16, insert:

"SECTION 16. AND BE IT FURTHER ENACTED, That, for Fiscal Year 1999 only, that portion of the special fund appropriation to the Health Resources Planning Commission that relates to the Commission's duties and responsibilities for the State health plan shall be transferred to the Department of Health and Mental Hygiene to enable the Department to perform the duties and responsibilities related to the State health plan, as transferred to the Department under this Act.

SECTION 17. AND BE IT FURTHER ENACTED, That the authority of the Health Resources Planning Commission, the Health Services Cost Review Commission, Health Care Access and Cost Commission to assess and collect user fees under §§ 19-122, 19-207.1, and 19-1515 of the Health - General Article, respectively, as repealed under Section 1 of this Act, shall remain in effect until the end of Fiscal Year 1999.

SECTION 18. AND BE IT FURTHER ENACTED, That:

(a) the changes to § 19-121 of the Health - General Article, as enacted by this Act, that alter the requirements under which a person is required to obtain a certificate of need or an exemption from having to obtain a certificate of need do not apply to any person that has on or before January 1, 1998 applied for or is awaiting a determination on an application for a certificate of need or an exemption from having to obtain a certificate of need; and

(b) in addition to the subsection (a) of this section, the changes to § 19-121(h)(2)(i) of the Health - General Article, as enacted by this Act, shall apply to any person that has not filed on or before January 1, 1998 for an exemption from having to obtain a certificate of need.

SECTION 19. AND BE IT FURTHER ENACTED, That the provisions of § 19-111 of the Health - General Article, as enacted under Section 3 of this Act, shall take effect July 1, 1999.";

in line 17, strike "Sections 5 and 6" and substitute "Section 5"; and in line 20, strike "Section 10" and substitute "Sections 19 and 20".

(Over)