Unofficial Copy 2003 Regular Session
J3 3lr1714

By: **Delegate Hurson**
Introduced and read first time: February 7, 2003
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Maryland Health Care Commission - Hospital-Based Health Care Practitioner Payment System

FOR the purpose of requiring the Maryland Health Care Commission to develop and implement a certain payment system for certain health care practitioners in the State; establishing certain requirements for the payment system; establishing a certain date by which the payment system is required to be implemented; requiring the Commission to establish certain standards and consider certain factors in developing the system; requiring the Commission and the licensing boards to develop certain sanctions under certain circumstances; requiring the Commission to consider certain factors in making certain determinations; authorizing the Commission to take certain actions with regard to certain health care practitioners; requiring the Commission to publish certain information on an annual basis; authorizing the Commission to establish certain goals with regard to health care costs and specifying how those goals are to be developed; clarifying the effect of this Act on certain health maintenance organization contracts; providing that a professional organization or society that performs activities in good faith in furtherance of the purposes of this Act is not subject to criminal or civil liability under the Maryland Anti-Trust Act for those activities; defining certain terms; requiring the Commission to undertake a certain study and issue a certain report by a certain date; and generally relating to development of a practitioner payment system by the Maryland Health Care Commission.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-103
Annotated Code of Maryland
(2000 Replacement Volume and 2002 Supplement)

BY adding to
Article - Health - General
Section 19-142
Annotated Code of Maryland

(2000 Replacement Volume and 2002 Supplement)

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

Article - Health - General

19-103.

(a) There is a Maryland Health Care Commission.

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

(c) The purpose of the Commission is to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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;

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

(13) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors; AND

(14) DEVELOP A PAYMENT SYSTEM FOR HOSPITAL-BASED HEALTH CARE PRACTITIONERS.

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

19-142.

(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) "HOSPITAL-BASED HEALTH CARE PRACTITIONER" MEANS:

(I) AN EMERGENCY ROOM PHYSICIAN;

(II) A RADIOLOGIST;

(III) AN ANESTHESIOLOGIST; AND

(IV) ANY OTHER HEALTH CARE PROVIDER WHO PRACTICES PREDOMINATELY IN A HOSPITAL.

(4) "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.

(5) "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, 2005, THE COMMISSION SHALL IMPLEMENT A PAYMENT SYSTEM FOR HOSPITAL-BASED HEALTH CARE PRACTITIONERS IN THE STATE.

(2) THE PAYMENT SYSTEM ESTABLISHED UNDER THIS SECTION SHALL INCLUDE A METHODOLOGY FOR A UNIFORM SYSTEM OF HOSPITAL-BASED HEALTH CARE PRACTITIONER REIMBURSEMENT.

(3) UNDER THE PAYMENT SYSTEM, REIMBURSEMENT FOR EACH HOSPITAL-BASED HEALTH CARE PRACTITIONER SHALL BE COMPRISED OF THE FOLLOWING NUMERIC FACTORS:

(I) A NUMERIC FACTOR REPRESENTING THE RESOURCES OF THE HOSPITAL-BASED HEALTH CARE PRACTITIONER NECESSARY TO PROVIDE HEALTH CARE SERVICES;

(II) A NUMERIC FACTOR REPRESENTING THE RELATIVE VALUE OF A HEALTH CARE SERVICE, AS CLASSIFIED BY A CODE, COMPARED TO THAT OF OTHER HEALTH CARE SERVICES; AND

(III) A NUMERIC FACTOR REPRESENTING A CONVERSION MODIFIER USED TO ADJUST REIMBURSEMENT.

(4) TO PREVENT OVERPAYMENT OF CLAIMS FOR SURGERY OR SERVICES, IN DEVELOPING THE PAYMENT SYSTEM UNDER THIS SECTION, THE COMMISSION, TO THE EXTENT PRACTICABLE, SHALL ESTABLISH STANDARDS TO PROHIBIT THE UNBUNDLING OF CODES AND THE USE OF REIMBURSEMENT MAXIMIZATION PROGRAMS, COMMONLY KNOWN AS "UPCODING".

(5) IN DEVELOPING THE PAYMENT SYSTEM UNDER THIS SECTION, THE COMMISSION SHALL CONSIDER THE UNDERLYING METHODOLOGY USED IN THE RESOURCE-BASED RELATIVE VALUE SCALE ESTABLISHED UNDER THE FEDERAL MEDICARE PROGRAM.

(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

HOSPITAL-BASED 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 HOSPITAL-BASED 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 HOSPITAL-BASED 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 CONSIDERED 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 CONSIDERED APPROPRIATE BY THE COMMISSION.

(3) IN MAKING A DETERMINATION UNDER SUBSECTION (B)(3)(II) OF THIS SECTION CONCERNING THE VALUE OF A HOSPITAL-BASED 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 CONSIDERED 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 HOSPITAL-BASED HEALTH CARE PRACTITIONER'S STANDARD FOR REIMBURSEMENT; OR

(III) ARRANGEMENTS AGREED UPON BETWEEN A PAYOR AND A HOSPITAL-BASED 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 HOSPITAL-BASED 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. HOSPITAL-BASED HEALTH CARE PRACTITIONERS IN A SPECIALTY AREA HAVE ATTAINED UNREASONABLE LEVELS OF REIMBURSABLE SERVICES UNDER A SPECIFIC CODE IN COMPARISON TO HOSPITAL-BASED HEALTH CARE PRACTITIONERS IN ANOTHER SPECIALTY AREA FOR THE SAME CODE;

3. HOSPITAL-BASED HEALTH CARE PRACTITIONERS IN A SPECIALTY AREA HAVE ATTAINED UNREASONABLE LEVELS OF REIMBURSEMENT, IN TERMS OF TOTAL COMPENSATION, IN COMPARISON TO HOSPITAL-BASED 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 HOSPITAL-BASED HEALTH CARE PRACTITIONERS HAVE BEEN UNSUCCESSFUL IN BRINGING THE APPROPRIATE HOSPITAL-BASED 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 HOSPITAL-BASED HEALTH CARE PRACTITIONER IN THAT SPECIALTY GROUP MAY NOT BE REIMBURSED MORE THAN AN AMOUNT EQUAL TO THE AMOUNT DETERMINED ACCORDING TO THE FACTORS SET FORTH IN SUBSECTION (B)(3)(I) AND (II) OF THIS SECTION AND THE CONVERSION MODIFIER ESTABLISHED BY THE COMMISSION.

(E) (1) ON AN ANNUAL BASIS, THE COMMISSION SHALL PUBLISH:

(I) THE TOTAL REIMBURSEMENT FOR ALL HEALTH CARE SERVICES DELIVERED BY A HOSPITAL-BASED HEALTH CARE PRACTITIONER OVER A 12-MONTH PERIOD;

(II) THE TOTAL REIMBURSEMENT FOR EACH HOSPITAL-BASED 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 HOSPITAL-BASED 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 CONSIDERS APPROPRIATE.

(F) THE COMMISSION MAY ESTABLISH HEALTH CARE COST ANNUAL ADJUSTMENT GOALS FOR THE COST OF HEALTH CARE SERVICES AND MAY ESTABLISH THE TOTAL COST OF HEALTH CARE SERVICES BY CODE TO BE RENDERED BY A SPECIALTY GROUP OF HOSPITAL-BASED 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 HOSPITAL-BASED 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 THE STATE AND IN THE UNITED STATES;

(II) THE RESOURCES NECESSARY FOR THE DELIVERY OF QUALITY HEALTH CARE;

(III) THE ADDITIONAL COSTS ASSOCIATED WITH AGING POPULATIONS AND NEW TECHNOLOGY;

(IV) THE POTENTIAL IMPACTS OF FEDERAL LAWS ON HEALTH CARE COSTS; AND

(V) THE SAVINGS ASSOCIATED WITH THE IMPLEMENTATION OF MODIFIED PRACTICE PATTERNS.

(H) THIS SECTION MAY NOT HAVE THE EFFECT OF IMPAIRING THE ABILITY OF A HEALTH MAINTENANCE ORGANIZATION TO CONTRACT WITH HOSPITAL-BASED HEALTH CARE PRACTITIONERS OR ANY OTHER INDIVIDUAL UNDER MUTUALLY AGREED UPON TERMS AND CONDITIONS.

(I) A PROFESSIONAL ORGANIZATION OR SOCIETY THAT PERFORMS ACTIVITIES IN GOOD FAITH IN FURTHERANCE OF THE PURPOSES OF THIS SECTION IS NOT SUBJECT TO CRIMINAL OR CIVIL LIABILITY UNDER THE MARYLAND ANTI-TRUST ACT FOR THOSE ACTIVITIES.

SECTION 2. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission shall conduct a study of the feasibility of obtaining a Medicare waiver that would enable the federal Medicare program to participate in the practitioner payment system established by this Act. The Commission shall report on the results of its study to the Senate Finance Committee and the House Health and Government Operations Committee on or before January 1, 2004, in accordance with § 2-1246 of the State Government Article.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2003.