J3 6lr0959

By: **Senator Pipkin**
Introduced and read first time: February 3, 2006
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Services Cost Review Commission - Repeal - Study of Alternative Financing of Uncompensated and Undercompensated Care

FOR the purpose of repealing provisions of law relating to the Health Services Cost Review Commission and its powers and duties; altering provisions of law relating to the Health Services Cost Review Commission; repealing a requirement that certain health facilities submit certain discharge information; repealing certain requirements regarding reimbursement rates set by the Health Services Cost Review Commission; requiring nonprofit hospitals to submit a certain report to the Maryland Health Care Commission; requiring the Maryland Health Care Commission to issue a certain annual report; requiring the Maryland Health Care Commission, in consultation with the Maryland Insurance Administration, to conduct a certain study; requiring the Maryland Health Care Commission to report to the Governor and to the General Assembly on the Commission's findings and recommendations on or before a certain date; providing for the termination of certain provisions of this Act; providing for a delayed effective date for certain provisions of this Act; and generally relating to health care financing.

BY repealing
Article - Health - General
Section 19-201 through 19-227, inclusive, and the subtitle "Subtitle 2. Health Services Cost Review Commission"; and 19-720
Annotated Code of Maryland
(2005 Replacement Volume and 2005 Supplement)

BY repealing
Article - Health - General
Section 2-106(a)(4), 15-103(b)(28), 15-105(d), 15-110, 19-118(d)(3), and 19-133(h)
Annotated Code of Maryland
(2005 Replacement Volume and 2005 Supplement)

BY repealing and reenacting, with amendments,

Article - Health - General
Section 10-628(a)(1), 13-310.1(c)(2), 15-103(b)(29) and (30), 15-105(e) and (f), 15-141(m)(1)(iv), 19-103(c)(1) and (13) and (d), 19-120(k)(5)(viii) and (ix), 19-133(i), 19-303, 19-307.2(c), 19-325, 19-3B-05(e), and 19-711.3
Annotated Code of Maryland
(2005 Replacement Volume and 2005 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 2-303.1(a)
Annotated Code of Maryland
(2003 Replacement Volume and 2005 Supplement)

BY repealing
Article - Insurance
Section 15-604 and 15-1214
Annotated Code of Maryland
(2002 Replacement Volume and 2005 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-906(a)(3)
Annotated Code of Maryland
(2002 Replacement Volume and 2005 Supplement)

BY renumbering
Article - Health - General
Section 2-106(a)(5) through (27), respectively
to be Section 2-106(a)(4) through (26), respectively
Annotated Code of Maryland
(2005 Replacement Volume and 2005 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 19-201 through 19-227, inclusive, and the subtitle "Subtitle 2. Health Services Cost Review Commission"; and 19-720 of Article - Health - General of the Annotated Code of Maryland be repealed.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

2-106.

(a) The following units are in the Department:

[(4) Health Services Cost Review Commission.]

10-628.

(a) (1) If an emergency evaluee cannot pay or does not have insurance that covers the charges for emergency services, an initial consultant examination by a physician and transportation to an emergency facility and, for an involuntary admission of the emergency evaluee, to the admitting facility, the Department shall pay the appropriate party the actual cost or a reasonable rate for this service, whichever is lower[, except that hospitals shall be paid at rates approved by the Health Services Cost Review Commission].

13-310.1.

(c) (2) The provisions of this section do not apply to[:

(i)] State-owned facilities[; or

(ii) Hospital services under the jurisdiction of the Health Services Cost Review Commission].

15-103.

(b) [(28) (i) The Department shall ensure that payments for services provided by a hospital located in a contiguous state or in the District of Columbia to an enrollee under the Program shall be reduced by 20% if the hospital fails to submit discharge data on all Maryland patients receiving care in the hospital to the Health Services Cost Review Commission in a form and manner the Commission specifies.

(ii) Subparagraph (i) of this paragraph does not apply to a hospital that presently provides discharge data to the public in a form the Health Services Cost Review Commission determines is satisfactory.]

[(29)] (28) A managed care organization shall provide coverage for hearing loss screenings of newborns provided by a hospital before discharge.

[(30)] (29) (i) The Department shall provide enrollees and health care providers with an accurate directory or other listing of all available providers:

1. In written form, made available upon request; and

2. On an Internet database.

(ii) The Department shall update the Internet database at least every 30 days.

(iii) The written directory shall include a conspicuous reference to the Internet database.

15-105.

[(d) (1) The Department shall adopt regulations for the reimbursement of specialty outpatient treatment and diagnostic services rendered to Program recipients at a freestanding clinic owned and operated by a hospital that is under a capitation agreement approved by the Health Services Cost Review Commission.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, the reimbursement rate under paragraph (1) of this subsection shall be set according to Medicare standards and principles for retrospective cost reimbursement as described in 42 CFR Part 413 or on the basis of charges, whichever is less.

(ii) The reimbursement rate for a hospital that has transferred outpatient oncology, diagnostic, rehabilitative, and digestive disease services to an off-site facility prior to January 1, 1999 shall be set according to the rates approved by the Health Services Cost Review Commission if:

1. The transfer of services was due to zoning restrictions at the hospital campus;

2. The off-site facility is surveyed as part of the hospital for purposes of accreditation by the Joint Commission on the Accreditation of Health Care Organizations; and

3. The hospital notifies the Health Services Cost Review Commission in writing by July 1, 1999 that the hospital would like the services provided at the off-site facility subject to Title 19, Subtitle 2 of this article.]

[(e)] (D) (1) In this subsection, "provider" means a community-based program or an individual health care practitioner providing outpatient mental health treatment.

(2) For an individual with dual eligibility, the Program shall reimburse a provider the entire amount of the Program fee for outpatient mental health treatment, including any amount ordinarily withheld as a psychiatric exclusion and any copayment not covered under Medicare.

[(f)] (E) This section has no effect if its operation would cause this State to lose any federal funds.

[15-110.

The Department shall reimburse acute general and chronic care hospitals that participate in the Program for care provided to Program recipients in accordance with rates that the Health Services Cost Review Commission approves under Title 19, Subtitle 2 of this article, if the United States Department of Health and Human Services approves this method of reimbursement.]

15-141.

(m) (1) In arranging for the benefits required under subsection (d) of this section, the community care organization shall:

(iv) Reimburse hospitals in accordance with the rates established by the [Health Services Cost Review Commission] DEPARTMENT;

19-103.

(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];

(13) Oversee and administer the Maryland Trauma Physician Services Fund [in conjunction with the Health Services Cost Review Commission].

(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.

19-118.

(d) [(3) In adopting standards regarding cost, efficiency, cost-effectiveness, or financial feasibility, the Commission shall take into account the relevant methodologies of the Health Services Cost Review Commission.]

19-120.

(k) (5) This subsection does not apply to:

(viii) A capital expenditure by a hospital as defined in § 19-301 of this title, for a project in excess of $1,250,000 for construction or renovation that:

1. May be related to patient care;

2. Does not require, over the entire period or schedule of debt service associated with the project, a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs associated with the project as determined by the Commission[, after consultation with the Health Services Cost Review Commission];

3. At least 45 days before the proposed expenditure is made, the hospital notifies the Commission and within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under item 2 of this subparagraph; and

4. The relevant financial information to be submitted by the hospital is defined in regulations adopted by the Commission[, after consultation with the Health Services Cost Review Commission]; or

(ix) A plant donated to a hospital as defined in § 19-301 of this title, which does not require a cumulative increase in patient charges or hospital rates of more than $1,500,000 for capital costs associated with the donated plant as determined by the Commission[, after consultation with the Health Services Cost Review Commission] that:

1. At least 45 days before the proposed donation is made, the hospital notifies the Commission and within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under this subparagraph; and

2. The relevant financial information to be submitted by the hospital is defined in regulations adopted by the Commission [after consultation with the Health Services Cost Review Commission].

19-133.

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

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

19-303.

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

(2) "Commission" means the [Health Services Cost Review Commission] MARYLAND HEALTH CARE COMMISSION.

(3) "Community benefit" means an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

(i) Health services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children's Health Program enrollees;

(ii) Financial or in kind support of public health programs;

(iii) Donations of funds, property, or other resources that contribute to a community priority;

(iv) Health care cost containment activities; and

(v) Health education, screening, and prevention services.

(4) "Community needs assessment" means the process by which unmet community health care needs and priorities are identified.

(b) In identifying community health care needs, a nonprofit hospital:

(1) Shall consider, if available, the most recent community needs assessment developed by the Department or the local health department for the county in which the nonprofit hospital is located;

(2) May consult with community leaders and local health care providers; and

(3) May consult with any appropriate person that can assist the hospital in identifying community health needs.

(c) (1) Each nonprofit hospital shall submit an annual community benefit report to the [Health Services Cost Review Commission] COMMISSION detailing the community benefits provided by the hospital during the preceding year.

(2) The community benefit report shall include:

(i) The mission statement of the hospital;

(ii) A list of the initiatives that were undertaken by the hospital;

(iii) The cost to the hospital of each community benefit initiative;

(iv) The objectives of each community benefit initiative;

(v) A description of efforts taken to evaluate the effectiveness of each community benefit initiative; and

(vi) A description of gaps in the availability of specialist providers to serve the uninsured in the hospital.

(d) (1) The Commission shall compile the reports required under subsection (c) of this section and issue an annual Nonprofit Hospital Community Health Benefit Report.

(2) In addition to the information required under paragraph (1) of this subsection, the Nonprofit Hospital Community Health Benefit Report shall contain a list of the unmet community health care needs identified in the most recent community needs assessment prepared by the Department or local health department for each county.

(3) The Nonprofit Hospital Community Health Benefit Report shall be made available to the public free of charge.

(4) The Commission shall submit a copy of the annual Nonprofit Hospital Community Health Benefit Report, subject to § 2-1246 of the State Government Article, to the House Health and Government Operations Committee and the Senate Finance Committee.

(e) The Commission shall adopt regulations, in consultation with representatives of nonprofit hospitals, that establish:

(1) A standard format for reporting the information required under this section;

(2) The date on which nonprofit hospitals must submit the annual community benefit reports; and

(3) The period of time that the annual community benefit report must cover.

19-307.2.

(c) If necessary to adequately meet demand for services, a hospital may exceed its licensed bed capacity if[:

(1) On] ON average for the 12-month period, the hospital does not exceed its licensed bed capacity based on the annual calculation[; and

(2) The hospital includes in its monthly report to the Health Services Cost Review Commission the following information:

(i) The number of days in the month the hospital exceeded its licensed bed capacity; and

(ii) The number of beds that were in excess on each of those days].

19-325.

(a) If voluntary efforts to reduce excess capacity prove insufficient, as a last resort the Maryland Health Care Commission [and the Health Services Cost Review Commission] may petition the Secretary to delicense any hospital or part of a hospital or hospital service based on a finding after a public hearing that the delicensure is consistent with the State health plan or institution-specific plan. The petition shall specify in detail all efforts made by the petitioner to encourage the hospital:

(1) To reduce its underutilized capacity;

(2) To merge or consolidate;

(3) To become more efficient and effective; and

(4) To convert from acute capacity to alternative uses, where appropriate.

(b) On petition by the Maryland Health Care Commission [and the Health Services Cost Review Commission], the Secretary may order that a hospital or part of a hospital or hospital service be delicensed if:

(1) The Secretary determines that delicensure is the last resort and a hospital or hospital services are excessive or inefficient, which determination is based on and is not inconsistent with the State health plan or institution-specific plan;

(2) An opportunity for notice and hearing in accordance with the Administrative Procedure Act has been given to the affected hospital, and in the affected political subdivision notice shall be given to the elected public officials and for at least 2 consecutive weeks in a newspaper of general circulation; and

(3) The hospital is not the sole provider of hospital services in a county for which the Commission [and Health Services Cost Review Commission have] HAS petitioned for all of the beds of the hospital to be delicensed.

(c) The Maryland Health Care Commission [and the Health Services Cost Review Commission are necessary parties] IS A NECESSARY PARTY to any proceeding in accordance with this section.

(d) Any person who is aggrieved by a final decision of the Secretary under this section may not appeal to the Board of Review, but may take a direct judicial appeal.

(e) The appeal shall be made as provided for judicial review of final decisions in the Administrative Procedure Act.

(f) The Secretary may participate in any appeal of a decision made in accordance with this section.

(g) In the event of an adverse decision that affects its final decision, the Secretary may apply within 30 days by writ of certiorari to the Court of Appeals for review where:

(1) Review is necessary to secure uniformity of decision, as where the same statute has been construed differently by 2 or more judges; or

(2) There are other special circumstances that render it desirable and in the public interest that the decision be reviewed.

19-3B-05.

(e) A license does not entitle the licensee to an exemption from other provisions of law relating to[:

(1) The review and approval of hospital rates and charges by the Health Services Cost Review Commission; or

(2) The] THE review and approval of new services or facilities by the Maryland Health Care Commission.

19-711.3.

In any case where a health maintenance organization is being merged or consolidated with or acquired by another person, any current financing moneys provided by the health maintenance organization to a hospital[, in accordance with regulations adopted by the Health Services Cost Review Commission,] in return for a discount in rates charged by the hospital shall be deemed to be security for the amount of outstanding charges owed by the health maintenance organization to the hospital for bills or claims for services provided by the hospital prior to the merger, consolidation, or acquisition.

Article - Insurance

2-303.1.

(a) The Administration shall serve as the single point of entry for consumers to access any and all information regarding health insurance and the delivery of health care as it relates to health insurance, including information prepared or collected by:

(1) the Department of Health and Mental Hygiene;

(2) the Maryland Health Care Commission;

(3) [the Health Services Cost Review Commission;

(4)] the Department of Aging; and

[(5)] (4) the Health Education and Advocacy Unit of the Attorney General's office.

[15-604.

Each authorized insurer, nonprofit health service plan, and fraternal benefit society, and each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health - General Article, shall pay hospitals for hospital services rendered on the basis of the rate approved by the Health Services Cost Review Commission.]

15-906.

(a) At a minimum, a Medicare supplement policy shall provide:

(3) after all Medicare hospital inpatient coverage is exhausted, including lifetime reserve days, subject to the lifetime maximum benefit of an additional 365 days, coverage of all Medicare Part A eligible expenses for hospitalization not covered by Medicare paid at the rate of the diagnostic related group (DRG) day outlier per

diem [or, if applicable, the per diem approved by the Health Services Cost Review Commission];

[15-1214.

Notwithstanding any other provision of this subtitle, health benefit plans shall reimburse hospitals in accordance with rates approved by the State Health Services Cost Review Commission.]

SECTION 3. AND BE IT FURTHER ENACTED, That Section(s) 2-106(a)(5) through (27), respectively, of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 2-106(a)(4) through (26), respectively.

SECTION 4. AND BE IT FURTHER ENACTED, That the publisher of the Annotated Code of Maryland, in consultation with and subject to the approval of the Department of Legislative Services, shall correct, with no further action required by the General Assembly, cross-references and terminology rendered incorrect by this Act or by any other Act of the General Assembly of 2006 that affects provisions enacted by this Act. The publisher shall adequately describe any such correction in an editor's note following the section affected.

SECTION 5. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission, in consultation with the Maryland Insurance Administration, shall conduct a study on:

(1) consumer-based methods of providing health insurance to the uninsured; and

(2) consumer-based methods of funding uncompensated and undercompensated care.

(b) In conducting the study, the Maryland Health Care Commission shall:

(1) examine methods of providing an affordable insurance product for the uninsured to purchase that would replace the current system of providing uncompensated care for the uninsured in hospitals;

(2) examine consumer-based alternative methods of funding uncompensated care and undercompensated care, including alternatives to the Maryland Health Insurance Plan and the Maryland Trauma Physician Services Fund; and

(3) provide comparisons of the costs of these alternative methods with the costs of current methods of funding of uncompensated care and undercompensated care in the State.

(c) The Maryland Health Care Commission shall report its findings and recommendations to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly, on or before October 1, 2008.

SECTION 6. AND BE IT FURTHER ENACTED, That Sections 1, 2, 3, and 4 of this Act shall take effect July 1, 2009.

SECTION 7. AND BE IT FURTHER ENACTED, That, except as provided in Section 6 of this Act, this Act shall take effect July 1, 2006. Section 5 of this Act shall remain effective for a period of 2 years and 6 months and, at the end of December 31, 2008, with no further action required by the General Assembly, Section 5 of this Act shall be abrogated and of no further force and effect.