SENATE BILL 620

J3 7lr0732
SB 528/06 – FIN

By: **Senator Pipkin**
Introduced and read first time: February 2, 2007
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Services Cost Review Commission – Repeal of Commission and 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; repealing a certain bond program for certain hospitals; 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 and the subtitle "Subtitle 2. Health Services Cost Review Commission"; and 19–720
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.
[Brackets**]** indicate matter deleted from existing law.

BY repealing
Article 43C – Maryland Health and Higher Educational Facilities Authority
Section 16A
Annotated Code of Maryland
(2003 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Education
Section 11–405
Annotated Code of Maryland
(2006 Replacement Volume)

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 2006 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)(6)(viii) and (ix), 19–130(b), (d), and (e), 19–133(i), 19–303, 19–307.2(c), 19–325, 19–3B–05(e), 19–710.1(b), and 19–711.3
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 2–303.1(a)
Annotated Code of Maryland
(2003 Replacement Volume and 2006 Supplement)

BY repealing
Article – Insurance
Section 15–604 and 15–1214
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance

Section 15–906(a)(3)
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – State Finance and Procurement
Section 7–403(b)
Annotated Code of Maryland
(2006 Replacement Volume and 2006 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 2006 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 19–201 through 19–227 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 Section(s) 16A of Article 43C – Maryland Health and Higher Educational Facilities Authority of the Annotated Code of Maryland be repealed.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Education

11–405.

(a) In this section, "Fund" means the Nurse Support Program Assistance Fund.

(b) (1) There is a Nurse Support Program Assistance Fund in the Commission.

(2) The Fund is a continuing, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The Treasurer shall separately hold and the Comptroller shall account for the Fund.

(4) The Fund shall be invested and reinvested in the same manner as other State funds.

(5) Any investment earnings of the Fund shall be paid into the Fund.

(c) The Fund consists of revenue **[**generated through an increase, as approved by the Health Services Cost Review Commission, to the rate structure of all hospitals in accordance with § 19–211 of the Health – General Article**]** **AS PROVIDED IN THE STATE BUDGET**.

(d) Expenditures from the Fund shall be made by an appropriation in the annual State budget or by approved budget amendment as provided under § 7–209 of the State Finance and Procurement Article.

(e) The money in the Fund shall be used for competitive grants and statewide grants to increase the number of qualified bedside nurses in Maryland hospitals in accordance with guidelines established by the Commission **[**and the Health Services Cost Review Commission**]**.

(f) The guidelines established under subsection (e) of this section shall provide that a portion of the competitive grants and statewide grants be used to attract and retain minorities to nursing and nurse faculty careers in Maryland.

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) (6) 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 $10,000,000 for construction or renovation **[**that**]** **IF**:

1. **[**May**]** **THE EXPENDITURE MAY** be related to patient care;

2. **[**Does**]** **THE EXPENDITURE 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

A. Within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under item 2 of this subparagraph; or

B. The Commission has not made the financial determination required under item 2 of this subparagraph within 60 days of the receipt of the relevant financial information; 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**]** **IF**:

1. At least 45 days before the proposed donation is made, the hospital notifies the Commission; and

A. Within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under this subparagraph; or

B. The Commission has not made the financial determination required under item 2 of this subparagraph within 60 days of the receipt of the relevant financial information; 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**]**.

19–130.

(b) (1) There is a Maryland Trauma Physician Services Fund.

(2) The purpose of the Fund is to subsidize the documented costs:

(i) Of uncompensated care incurred by a trauma physician in providing trauma care to a trauma patient on the State trauma registry;

(ii) Of undercompensated care incurred by a trauma physician in providing trauma care to an enrollee of the Maryland Medical Assistance Program who is a trauma patient on the State trauma registry;

(iii) Incurred by a trauma center to maintain trauma physicians on–call as required by the Maryland Institute for Emergency Medical Services Systems; and

(iv) Incurred by the Commission **[**and the Health Services Cost Review Commission**]** to administer the Fund and audit reimbursement requests to assure appropriate payments are made from the Fund.

(3) The Commission **[**and the Health Services Cost Review Commission**]** shall administer the Fund.

(4) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(5) Interest on and other income from the Fund shall be separately accounted for and credited to the Fund, and are not subject to § 6–226(a) of the State Finance and Procurement Article.

(d) (1) Disbursements from the Fund shall be made in accordance with a methodology established **[**jointly**]** by the Commission **[**and the Health Services Cost Review Commission**]** to calculate costs incurred by trauma physicians and trauma centers that are eligible to receive reimbursement under subsection (b) of this section.

(2) The Fund shall transfer to the Department of Health and Mental Hygiene an amount sufficient to fully cover the State's share of expenditures for the costs of undercompensated care incurred by a trauma physician in providing trauma care to an enrollee of the Maryland Medical Assistance Program who is a trauma patient on the State trauma registry.

(3) The methodology developed under paragraph (1) of this subsection shall:

(i) Take into account:

1. The amount of uncompensated care provided by trauma physicians;

2. The amount of undercompensated care attributable to the treatment of Medicaid enrollees in trauma centers;

3. The cost of maintaining trauma physicians on–call;

4. The number of patients served by trauma physicians in trauma centers;

5. The number of Maryland residents served by trauma physicians in trauma centers; and

6. The extent to which trauma–related costs are otherwise subsidized by hospitals, the federal government, and other sources; and

(ii) Include an incentive to encourage hospitals to continue to subsidize trauma–related costs not otherwise included in hospital rates.

(4) The methodology developed under paragraph (1) of this subsection shall use the following parameters to determine the amount of reimbursement made to trauma physicians and trauma centers from the Fund:

(i) 1. The cost incurred by a Level II trauma center to maintain trauma surgeons, orthopedic surgeons, and neurosurgeons on–call shall be reimbursed:

A. At a rate of up to 30% of the reasonable cost equivalents hourly rate for the specialty, inflated to the current year by the physician compensation component of the Medicare economic index as designated by the Centers for Medicare and Medicaid Services; and

B. For the minimum number of trauma physicians required to be on–call, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for Level II trauma centers;

2. The cost incurred by a Level III trauma center to maintain trauma surgeons, orthopedic surgeons, neurosurgeons, and anesthesiologists on–call shall be reimbursed:

A. At a rate of up to 35% of the reasonable cost equivalents hourly rate for the specialty, inflated to the current year by the physician compensation component of the Medicare economic index as designated by the Centers for Medicare and Medicaid Services; and

B. For the minimum number of trauma physicians required to be on–call, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for Level III trauma centers; and

3. A. A Level II trauma center is eligible for a maximum of 24,500 hours of trauma on–call per year; and

B. A Level III trauma center is eligible for a maximum of 35,040 hours of trauma on–call per year;

(ii) The cost of undercompensated care incurred by a trauma physician in providing trauma care to enrollees of the Maryland Medical Assistance Program who are trauma patients on the State trauma registry shall be reimbursed at a rate of up to 100% of the Medicare payment for the service, minus any amount paid by the Maryland Medical Assistance Program;

(iii) The cost of uncompensated care incurred by a trauma physician in providing trauma care to trauma patients on the State trauma registry shall be reimbursed at a rate of up to 100% of the Medicare payment for the service, minus any recoveries made by the trauma physician for the care; and

(iv) The total reimbursement to emergency physicians from the Fund may not exceed $275,000 annually.

(5) In order to receive reimbursement, a trauma physician in the case of costs of uncompensated care under subsection (b)(2)(i) of this section, or a trauma center in the case of on–call costs under subsection (b)(2)(iii) of this section, shall apply to the Fund on a form and in a manner approved by the Commission **[**and the Health Services Cost Review Commission**]**.

(6) (i) The Commission **[**and the Health Services Cost Review Commission**]** shall adopt regulations that specify the information that trauma physicians and trauma centers must submit to receive money from the Fund.

(ii) The information required shall include:

1. The name and federal tax identification number of the trauma physician rendering the service;

2. The date of the service;

3. Appropriate codes describing the service;

4. Any amount recovered for the service rendered;

5. The name of the trauma patient;

6. The patient's trauma registry number; and

7. Any other information the Commission **[**and the Health Services Cost Review Commission consider**]** **CONSIDERS** necessary to disburse money from the Fund.

(iii) It is the intent of the General Assembly that trauma physicians and trauma centers shall cooperate with the Commission **[**and the Health Services Cost Review Commission**]** by providing information required under this paragraph in a timely and complete manner.

(e) On or before September 1 of each year, the Commission **[**and the Health Services Cost Review Commission**]** shall report to the General Assembly, in accordance with § 2–1246 of the State Government Article, on:

(1) The amount of money in the Fund on the last day of the previous fiscal year;

(2) The amount of money applied for by trauma physicians and trauma centers during the previous fiscal year;

(3) The amount of money distributed in the form of trauma physician and trauma center reimbursements during the previous fiscal year;

(4) Any recommendations for altering the manner in which trauma physicians and trauma centers are reimbursed from the Fund;

(5) The costs incurred in administering the Fund during the previous fiscal year; and

(6) The amount that each hospital that participates in the Maryland trauma system and that has a trauma center contributes toward the subsidization of trauma–related costs for its trauma center.

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.

19–710.1.

(b) (1) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(i) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(ii) Shall pay the claim submitted by:

1. **[**A hospital at the rate approved by the Health Services Cost Review Commission;

2.**]** A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:

A. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or

B. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and

[3.**] 2.** Any other health care provider at the greater of:

A. 125% of the rate the health maintenance organization pays in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider under written contract with the health maintenance organization; or

B. The rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider not under written contract with the health maintenance organization.

(2) A health maintenance organization shall disclose, on request of a health care provider not under written contract with the health maintenance organization, the reimbursement rate required under paragraph **[**(1)(ii)2**] (1)(II)** of this subsection.

(3) (i) Subject to subparagraph (ii) of this paragraph, a health maintenance organization may require a trauma physician not under contract with the health maintenance organization to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the health maintenance organization.

(ii) If a health maintenance organization requires a trauma physician to include a provider number on the uniform claim form in accordance with subparagraph (i) of this paragraph, the health maintenance organization shall assign a provider number to a trauma physician not under contract with the health maintenance organization at the request of the physician.

(4) A trauma center, on request from a health maintenance organization, shall verify that a licensed physician is credentialed or otherwise designated by the trauma center to provide trauma care.

(5) Notwithstanding the provisions of § 19–701(d) of this subtitle, for trauma care rendered to a trauma patient in a trauma center by a trauma physician, a health maintenance organization may not require a referral or preauthorization for a service to be covered.

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.**]**

Article – State Finance and Procurement

7–403.

(b) This section does not apply to:

(1) a dentist;

(2) a hospital **[**that the State Health Services Cost Review Commission regulates**]**;

(3) a pharmacist; or

(4) a physician.

SECTION 4. 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 5. 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 6. 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;

(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; and

(4) examine alternative methods of funding any outstanding liabilities and obligations of the Maryland Hospital Bond Program.

(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, 2009.

SECTION 7. AND BE IT FURTHER ENACTED, That Sections 1, 2, 3, 4, and 5 of this Act shall take effect July 1, 2010.

SECTION 8. AND BE IT FURTHER ENACTED, That, except as provided in Section 7 of this Act, this Act shall take effect July 1, 2007. Section 6 of this Act shall remain effective for a period of 2 years and 6 months and, at the end of December 31, 2009, with no further action required by the General Assembly, Section 6 of this Act shall be abrogated and of no further force and effect.