CHAPTER 627

(House Bill 800)

AN ACT concerning

Maryland Health Care Commission – Program Evaluation

FOR the purpose of repealing the requirement that the Maryland Health Care Commission may not act on any matter unless a certain number of voting members in attendance concur; providing that a decision of the Commission shall be by a majority of the quorum present and voting; making permanent a certain authorization to assess a certain administrative charge to fund certain services; raising the amount of total fees that may be assessed by the Commission; providing that a majority of the full authorized membership of the Commission is a quorum to act on certain applications; altering the date by which the Commission shall provide a certain annual report; authorizing the Commission to compile certain data from certain facilities to be included in the medical care data base; altering certain requirements for the medical care data base related to information collected by the Health Services Cost Review Commission; repealing the requirement that the Commission conduct a certain study; repealing the requirement that the Commission annually determine the full cost of certain mandated health insurance services in the State; altering the information to be reported to the General Assembly in a certain annual report on mandated health insurance services; requiring the Commission to include certain information on mandated health insurance services in a certain evaluation and in certain reports to the General Assembly; providing for a certain evaluation of the Commission and the statutes and regulations that relate to the Commission on or before a certain date; requiring the Commission to include certain information regarding the Limited Health Benefit Plan in a certain report to certain committees of the General Assembly; requiring the Commission to include certain information in a certain workload distribution study and to report to certain committees of the General Assembly on or before a certain date; requiring the Commission to report to certain committees of the General Assembly on or before a certain date on the implementation of certain recommendations related to certificate of need; requiring the Commission to include certain information on the Maryland Trauma Physician Services Fund in a certain report; requiring the Commission to report to certain committees of the General Assembly on or before a certain date on the collection and use of certain data; requiring the Commission to report to certain committees of the General Assembly on or before a certain date on the implementation of

recommendations contained in a certain evaluation of the Commission; and generally relating to the program evaluation of the Maryland Health Care Commission.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–107(a), ~~19–111(e)(1),~~ 19–110(b), 19–111(c), 19–126(d)(2), 19–130(e), and 19–133
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–126(d)(1) and (13) and 19–130(b)(1)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing
Article – Health – General
Section 19–139
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–1501(c)
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY repealing
Article – Insurance
Section 15–1501(d)
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1501(e) and (f) and 15–1502
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, without amendments,

Article – State Government
Section 8–403(a)
Annotated Code of Maryland
(2004 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – State Government
Section 8–403(b)(27)
Annotated Code of Maryland
(2004 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Chapter 287 of the Acts of the General Assembly of 2004
Section 4

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

Article – Health – General

19–107.

(a) **(1)** A majority of the full authorized membership of the Commission is a quorum. **[**However, the Commission may not act on any matter unless at least seven of the voting members in attendance concur.**]**

(2) THE DECISION OF THE COMMISSION SHALL BE BY A MAJORITY OF THE QUORUM PRESENT AND VOTING.

19–110.

(b) **(1)** The power of the Secretary to transfer, by rule, regulation, or written directive, any staff, functions, or funds of units in the Department does not apply to any staff, function, or funds of the Commission.

(2) **[**For fiscal year 2007, the**]** **THE** Secretary may assess an administrative charge, consistent with the indirect cost charge assessed to federal grants, to fund services provided to the Commission by the Executive Branch.

19–111.

(c) (1) The total fees assessed by the Commission may not exceed **[**$10,000,000**]** **$12,000,000**.

(2) **(I)** The fees assessed by the Commission shall be used exclusively to cover the actual documented direct costs of fulfilling the statutory and regulatory duties of the Commission in accordance with the provisions of this subtitle.

(II) **[**For the fiscal year 2007, the**]** **THE** costs of the Commission include the administrative costs incurred by the Department on behalf of the Commission.

(III) The amount to be paid by the Commission to the Department for administrative costs, not to exceed 18% of the salaries of the Commission, shall be based on indirect costs or services benefiting the Commission, less overhead costs paid directly by the Commission.

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

(4) The fees assessed may be expended only for purposes authorized by the provisions of this subtitle.

(5) The amount in paragraph (1) of this subsection limits only the total fees the Commission may assess in a fiscal year.

19–126.

(d) (1) The Commission alone shall have final nondelegable authority to act upon an application for a certificate of need, except as provided in this subsection.

(2) **[**Seven voting members**]** **A MAJORITY OF THE FULL AUTHORIZED MEMBERSHIP** of the Commission shall be a quorum to act on an application for a certificate of need.

(13) The decision of the Commission shall be by a majority of the quorum present and voting.

19–130.

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

(e) On or before **[**September 1**]** **NOVEMBER 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.

(a) In this section, "code" means:

(1) The applicable Current Procedural Terminology (CPT) code as adopted by the American Medical Association; or

(2) If a CPT code is not available, the applicable code under an appropriate uniform coding scheme approved by the Commission.

(b) The Commission shall establish a Maryland medical care data base to compile statewide data on health services rendered by health care practitioners and **[**office**]** facilities selected by the Commission.

(c) In addition to any other information the Commission may require by regulation, the medical care data base shall:

(1) Collect for each type of patient encounter with a health care practitioner or **[**office**]** facility designated by the Commission:

(i) The demographic characteristics of the patient;

(ii) The principal diagnosis;

(iii) The procedure performed;

(iv) The date and location of where the procedure was performed;

(v) The charge for the procedure;

(vi) If the bill for the procedure was submitted on an assigned or nonassigned basis;

(vii) If applicable, a health care practitioner's universal identification number; and

(viii) If the health care practitioner rendering the service is a certified registered nurse anesthetist or certified nurse midwife, identification modifiers for the certified registered nurse anesthetist or certified nurse midwife;

(2) Collect appropriate information relating to prescription drugs for each type of patient encounter with a pharmacist designated by the Commission; and

(3) Collect appropriate information relating to health care costs, utilization, or resources from payors and governmental agencies.

(d) (1) The Commission shall adopt regulations governing the access and retrieval of all medical claims data and other information collected and stored in the medical care data base and any claims clearinghouse licensed by the Commission and may set reasonable fees covering the costs of accessing and retrieving the stored data.

(2) These regulations shall ensure that confidential or privileged patient information is kept confidential.

(3) Records or information protected by the privilege between a health care practitioner and a patient, or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the person protected.

(e) (1) To the extent practicable, when collecting the data required under subsection (c) of this section, the Commission shall utilize any standardized claim form

or electronic transfer system being used by health care practitioners, **[**office**]** facilities, and payors.

(2) The Commission shall develop appropriate methods for collecting the data required under subsection (c) of this section on subscribers or enrollees of health maintenance organizations.

(f) Until the provisions of § 19–134 of this subtitle are fully implemented, where appropriate, the Commission may limit the data collection under this section.

(g) (1) By October 1, 1995 and each year thereafter, the Commission shall publish an annual report on those health care services selected by the Commission that:

(i) Describes the variation in fees charged by health care practitioners and **[**office**]** facilities on a statewide basis and in each health service area for those health care services; and

(ii) Describes the geographic variation in the utilization of those health care services.

(2) (i) On an annual basis, the Commission shall publish:

1. The total reimbursement for all health care services over a 12–month period;

2. The total reimbursement for each health care specialty over a 12–month period;

3. The total reimbursement for each code over a 12–month period; and

4. The annual rate of change in reimbursement for health services by health care specialties and by code.

(ii) In addition to the information required under subparagraph (i) of this paragraph, the Commission may publish any other information that the Commission deems appropriate, including information on capitated health care services.

(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**]** **WITH** information collected by the Health Services Cost Review Commission.

(i) 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.

[19–139.

(a) The Commission, in consultation with the Department of Health and Mental Hygiene, shall study the feasibility of developing a system for reducing the incidences of preventable adverse medical events in the State including but not limited to a system of reporting such incidences.

(b) In conducting the study the Commission shall review:

(1) Federal reports and recommendations for identification of medical errors including the most recent report of the Institute of Medicine of the National Academy of Sciences;

(2) Recommendations of national accrediting and quality assurance organizations including the Joint Commission on the Accreditation of Health Care Organizations;

(3) Recommendations of the National Quality Forum;

(4) Programs in other states designed to reduce adverse medical events; and

(5) Best practices of hospitals and other health care facilities.**]**

Article – Insurance

15–1501.

(c) (1) The Commission shall assess the social, medical, and financial impacts of a proposed mandated health insurance service.

(2) In assessing a proposed mandated health insurance service and to the extent that information is available, the Commission shall consider:

(i) social impacts, including:

1. the extent to which the service is generally utilized by a significant portion of the population;

2. the extent to which the insurance coverage is already generally available;

3. if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments;

4. if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;

5. the level of public demand for the service;

6. the level of public demand for insurance coverage of the service;

7. the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and

8. the extent to which the mandated health insurance service is covered by self–funded employer groups of employers in the State who employ at least 500 employees;

(ii) medical impacts, including:

1. the extent to which the service is generally recognized by the medical community as being effective and efficacious in the treatment of patients;

2. the extent to which the service is generally recognized by the medical community as demonstrated by a review of scientific and peer review literature; and

3. the extent to which the service is generally available and utilized by treating physicians; and

(iii) financial impacts, including:

1. the extent to which the coverage will increase or decrease the cost of the service;

2. the extent to which the coverage will increase the appropriate use of the service;

3. the extent to which the mandated service will be a substitute for a more expensive service;

4. the extent to which the coverage will increase or decrease the administrative expenses of insurers and the premium and administrative expenses of policy holders;

5. the impact of this coverage on the total cost of health care; and

6. the impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs.

[(d) (1) In addition to the information required under subsection (c) of this section, the Commission shall annually determine the full cost of all existing mandated health insurance services in the State:

(i) as a percentage of Maryland's average annual wage; and

(ii) as a percentage of health insurance premiums.

(2) In making its determination, the Commission shall consider the full cost of the existing mandated health insurance services:

(i) under a typical group and individual health benefit plan in this State;

(ii) under the State employee health benefit plan for medical coverage; and

(iii) under the Comprehensive Standard Health Benefit Plan as defined in § 15–1201(q) of this title.**]**

[(e)**] (D)** Subject to the limitations of the State budget, the Commission may contract for actuarial services and other professional services to carry out the provisions of this section.

[(f)**] (E)** (1) On or before December 31, 1998, and each December 31 thereafter, the Commission shall submit a report on its findings, including any recommendations, to the Governor and, subject to § 2–1246 of the State Government Article, the General Assembly.

(2) The annual report prepared by the Commission shall include an evaluation of any mandated health insurance service **[**enacted,**]** legislatively proposed**[**,**]** or otherwise submitted to the Commission by a member of the General Assembly prior to July 1 of that year.

15–1502.

(a) (1) The Commission shall conduct an evaluation of existing mandated health insurance services and make recommendations to the General Assembly regarding decision making criteria for reducing the number of mandates or the extent of coverage.

(2) The evaluation shall include:

(i) an assessment of the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of **[**premiums for the individual and group health insurance market;**]** **PREMIUMS:**

1. UNDER A TYPICAL GROUP AND INDIVIDUAL HEALTH BENEFIT PLAN IN THE STATE;

2. UNDER THE STATE EMPLOYEE HEALTH BENEFIT PLAN; AND

3. UNDER THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN;

(ii) an assessment of the degree to which existing mandated health insurance services are covered in self–funded plans; and

(iii) a comparison of mandated health insurance services provided by the State with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia.

(3) The comparison described in paragraph (2)(iii) of this subsection shall include:

(i) the number of mandated health insurance services;

(ii) the type of mandated health insurance services;

(iii) the level and extent of coverage for each mandated health insurance service; and

(iv) the financial impact of differences in levels of coverage for each mandated health insurance service.

(4) On or before January 1, 2004, and every 4 years thereafter, the Commission shall submit a report of its findings to the General Assembly, subject to § 2–1246 of the State Government Article.

(b) The General Assembly may consider the information provided under subsection (a) of this section in determining:

(1) whether to enact proposed mandated health insurance services; and

(2) whether to repeal existing mandated health insurance services.

Article – State Government

8–403.

(a) On or before December 15 of the 2nd year before the evaluation date of a governmental activity or unit, the Legislative Policy Committee, based on a preliminary evaluation, may waive as unnecessary the evaluation required under this section.

(b) Except as otherwise provided in subsection (a) of this section, on or before the evaluation date for the following governmental activities or units, an evaluation shall be made of the following governmental activities or units and the statutes and regulations that relate to the governmental activities or units:

(27) Health Care Commission, Maryland (§ 19–103 of the Health – General Article: **[**July 1, 2007**]** **JULY 1, 2017**);

Chapter 287 of the Acts of 2004

SECTION 4. AND BE IT FURTHER ENACTED, That, on or before January 1, 2008, the Maryland Health Care Commission shall submit to the Governor and, in accordance with § 2–1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee, a report that includes:

(a) for the periods July 1, 2005 through December 31, 2005, January 1, 2006 through December 31, 2006, and January 1, 2007 through June 30, 2007, data on:

(1) the number of carriers offering Limited Health Benefit Plan policies in the State;

(2) the number of Limited Health Benefit Plan policies sold in the State;

(3) the number of eligible employees covered under the policies;

(4) the average age, geographic area, and average wage of each employer group covered under the policies; and

(5) the impact of the Limited Health Benefit Plan on the small group health insurance market and the population of uninsured individuals in the State; **[**and**]**

(b) recommendations on continuing or expanding the availability of the Limited Health Benefit Plan in the small group health insurance market**; AND**

(C) ALTERNATIVE INSURANCE OPTIONS FOR INDIVIDUALS ENROLLED IN THE LIMITED HEALTH BENEFIT PLAN.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) the Maryland Health Care Commission shall include in the next workload distribution study required under § 19–111(d) of the Health – General Article:

(1) the extent to which health care providers that are not currently subject to a user fee assessment utilize Commission resources; and

(2) the feasibility and desirability of extending a user fee to additional types of providers regulated by the Commission; and

(b) on or before December 1, 2008, the Commission shall report its findings and recommendations to the Senate Finance Committee and the House Health and Government Operations Committee in accordance with § 2–1246 of the State Government Article.

SECTION 3. AND BE IT FURTHER ENACTED, That on or before October 1, 2007, and on or before October 1, 2008, the Maryland Health Care Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1246 of the State Government Article, on:

(a) the implementation of the recommendations of the 2005 Certificate of Need Task Force; and

(b) the progress of the Commission in implementing the recommendations of the comprehensive evaluation of Certificate of Need required by Chapter 702 of the Acts of 1999, including recommendations regarding:

(1) a research project for elective angioplasty; and

(2) a reorganization of the licensing and certificate of need laws for home–based health care services.

SECTION 4. AND BE IT FURTHER ENACTED, That:

(a) the Maryland Health Care Commission and the Health Services Cost Review Commission shall include in the next report on the Maryland Trauma Physician Services Fund required under § 19–130(e) of the Health – General Article a discussion of options for reducing the Fund surplus, including:

(1) one–time–only uses for eliminating the large surplus that has accrued in the early years of the Fund;

(2) if the surplus is continuing to grow, ongoing uses to align annual expenditures with annual revenues; and

(3) the desirability of providing funds directly to trauma centers for the purpose of subsidizing trauma physician costs at the centers; and

(b) on or before November 1, 2007, the Commissions shall report their findings and recommendations to the General Assembly, in accordance with § 2–1246 of the State Government Article.

SECTION 5. AND BE IT FURTHER ENACTED, That, to provide a more complete picture of health care spending than current data collection efforts allow, on or before October 1, 2007, the Maryland Health Care Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1246 of the State Government Article, on:

(a) the Commission's plans to collect data on facility costs and insurance product design, in addition to the data currently collected on practitioner costs; and

(b) how the data collected under paragraph (a) of this section would be used to promote quality and affordable health care.

SECTION 6. AND BE IT FURTHER ENACTED, That on or before October 1, 2007, the Maryland Health Care Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1246 of the State Government Article, on the implementation of the recommendations contained in the 2006 Evaluation of the Maryland Health Care Commission.

SECTION 7. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2007.

Approved by the Governor, May 17, 2007.