

HOUSE BILL 1070

J3
SB 528/06 – FIN

71r3032
CF SB 620

By: **Delegates Eckardt, Dwyer, Haddaway, McComas, Schuh, and Smigiel**
Introduced and read first time: February 9, 2007
Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Services Cost Review Commission – Repeal of Commission and Study**
3 **of Alternative Financing of Uncompensated and Undercompensated Care**

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

20 BY repealing

21 Article – Health – General
22 Section 19–201 through 19–227 and the subtitle “Subtitle 2. Health
23 Services Cost Review Commission”; and 19–720
24 Annotated Code of Maryland
25 (2005 Replacement Volume and 2006 Supplement)

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



- 1 BY repealing
2 Article 43C – Maryland Health and Higher Educational Facilities Authority
3 Section 16A
4 Annotated Code of Maryland
5 (2003 Replacement Volume and 2006 Supplement)
- 6 BY repealing and reenacting, with amendments,
7 Article – Education
8 Section 11–405
9 Annotated Code of Maryland
10 (2006 Replacement Volume)
- 11 BY repealing
12 Article – Health – General
13 Section 2–106(a)(4), 15–103(b)(28), 15–105(d), 15–110, 19–118(d)(3), and
14 19–133(h)
15 Annotated Code of Maryland
16 (2005 Replacement Volume and 2006 Supplement)
- 17 BY repealing and reenacting, with amendments,
18 Article – Health – General
19 Section 10–628(a)(1), 13–310.1(c)(2), 15–103(b)(29) and (30), 15–105(e) and (f),
20 15–141(m)(1)(iv), 19–103(c)(1) and (13) and (d), 19–120(k)(6)(viii) and (ix),
21 19–130(b), (d), and (e), 19–133(i), 19–303, 19–307.2(c), 19–325,
22 19–3B–05(e), 19–710.1(b), and 19–711.3
23 Annotated Code of Maryland
24 (2005 Replacement Volume and 2006 Supplement)
- 25 BY repealing and reenacting, with amendments,
26 Article – Insurance
27 Section 2–303.1(a)
28 Annotated Code of Maryland
29 (2003 Replacement Volume and 2006 Supplement)
- 30 BY repealing
31 Article – Insurance
32 Section 15–604 and 15–1214
33 Annotated Code of Maryland
34 (2006 Replacement Volume and 2006 Supplement)
- 35 BY repealing and reenacting, with amendments,
36 Article – Insurance

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

4 BY repealing and reenacting, with amendments,
5 Article – State Finance and Procurement
6 Section 7–403(b)
7 Annotated Code of Maryland
8 (2006 Replacement Volume and 2006 Supplement)

9 BY renumbering
10 Article – Health – General
11 Section 2–106(a)(5) through (27), respectively
12 to be Section 2–106(a)(4) through (26), respectively
13 Annotated Code of Maryland
14 (2005 Replacement Volume and 2006 Supplement)

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

19 SECTION 2. AND BE IT FURTHER ENACTED, That Section(s) 16A of Article
20 43C – Maryland Health and Higher Educational Facilities Authority of the Annotated
21 Code of Maryland be repealed.

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

24 **Article – Education**

25 11–405.

26 (a) In this section, “Fund” means the Nurse Support Program Assistance
27 Fund.

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

30 (2) The Fund is a continuing, nonlapsing fund that is not subject to §
31 7–302 of the State Finance and Procurement Article.

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

1 13-310.1.

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

3 (i)] State-owned facilities[; or

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

6 15-103.

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

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

15 [(29) (28) A managed care organization shall provide coverage for
16 hearing loss screenings of newborns provided by a hospital before discharge.

17 [(30) (29) (i) The Department shall provide enrollees and health
18 care providers with an accurate directory or other listing of all available providers:

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

20 2. On an Internet database.

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

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

25 15-105.

26 [(d) (1) The Department shall adopt regulations for the reimbursement of
27 specialty outpatient treatment and diagnostic services rendered to Program recipients

1 at a freestanding clinic owned and operated by a hospital that is under a capitation
2 agreement approved by the Health Services Cost Review Commission.

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

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

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

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

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

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

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

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

28 [15–110.

29 The Department shall reimburse acute general and chronic care hospitals that
30 participate in the Program for care provided to Program recipients in accordance with
31 rates that the Health Services Cost Review Commission approves under Title 19,

1 Subtitle 2 of this article, if the United States Department of Health and Human
2 Services approves this method of reimbursement.]

3 15–141.

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

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

8 19–103.

9 (c) The purpose of the Commission is to:

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

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

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

18 19–118.

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

22 19–120.

23 (k) (6) This subsection does not apply to:

24 (viii) A capital expenditure by a hospital as defined in § 19–301 of
25 this title, for a project in excess of \$10,000,000 for construction or renovation [that] **IF**:

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

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

6 3. At least 45 days before the proposed expenditure is
7 made, the hospital notifies the Commission; and

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

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

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

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

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

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

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

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

1 19–130.

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

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

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

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

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

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

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

17 (4) The Fund is a special, nonlapsing fund that is not subject to §
18 7–302 of the State Finance and Procurement Article.

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

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

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

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

3 (i) Take into account:

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

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

8 3. The cost of maintaining trauma physicians on-call;

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

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

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

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

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

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

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

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

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

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

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

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

13 B. A Level III trauma center is eligible for a maximum of
14 35,040 hours of trauma on-call per year;

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

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

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

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

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

- 1 (ii) The information required shall include:
- 2 1. The name and federal tax identification number of the
3 trauma physician rendering the service;
- 4 2. The date of the service;
- 5 3. Appropriate codes describing the service;
- 6 4. Any amount recovered for the service rendered;
- 7 5. The name of the trauma patient;
- 8 6. The patient's trauma registry number; and
- 9 7. Any other information the Commission [and the
10 Health Services Cost Review Commission consider] **CONSIDERS** necessary to disburse
11 money from the Fund.

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

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

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

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

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

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

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

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

6 19–133.

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

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

17 19–303.

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

19 (2) “Commission” means the [Health Services Cost Review
20 Commission] **MARYLAND HEALTH CARE COMMISSION**.

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

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

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

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

30 (iv) Health care cost containment activities; and

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

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

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

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

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

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

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

15 (2) The community benefit report shall include:

16 (i) The mission statement of the hospital;

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

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

19 (iv) The objectives of each community benefit initiative;

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

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

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

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

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

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

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

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

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

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

20 19–307.2.

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

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

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

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

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

1 19-325.

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

8 (1) To reduce its underutilized capacity;

9 (2) To merge or consolidate;

10 (3) To become more efficient and effective; and

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

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

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

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

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

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

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

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

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

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

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

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

15 19-3B-05.

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

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

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

22 19-710.1.

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

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

29 (ii) Shall pay the claim submitted by:

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

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

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

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

12 [3.] 2. Any other health care provider at the greater
13 of:

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

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

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

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

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

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

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

13 19-711.3.

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

22 Article - Insurance

23 2-303.1.

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

28 (1) the Department of Health and Mental Hygiene;

29 (2) the Maryland Health Care Commission;

30 (3) [the Health Services Cost Review Commission;

31 (4)] the Department of Aging; and

1 [(5)] (4) the Health Education and Advocacy Unit of the Attorney
2 General's office.

3 [15-604.

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

9 15-906.

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

11 (3) after all Medicare hospital inpatient coverage is exhausted,
12 including lifetime reserve days, subject to the lifetime maximum benefit of an
13 additional 365 days, coverage of all Medicare Part A eligible expenses for
14 hospitalization not covered by Medicare paid at the rate of the diagnostic related
15 group (DRG) day outlier per diem [or, if applicable, the per diem approved by the
16 Health Services Cost Review Commission];

17 [15-1214.

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

21 **Article – State Finance and Procurement**

22 7-403.

23 (b) This section does not apply to:

24 (1) a dentist;

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

27 (3) a pharmacist; or

1 (4) a physician.

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

5 SECTION 5. AND BE IT FURTHER ENACTED, That the publisher of the
6 Annotated Code of Maryland, in consultation with and subject to the approval of the
7 Department of Legislative Services, shall correct, with no further action required by
8 the General Assembly, cross–references and terminology rendered incorrect by this
9 Act or by any other Act of the General Assembly of 2006 that affects provisions
10 enacted by this Act. The publisher shall adequately describe any such correction in an
11 editor’s note following the section affected.

12 SECTION 6. AND BE IT FURTHER ENACTED, That:

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

15 (1) consumer–based methods of providing health insurance to the
16 uninsured; and

17 (2) consumer–based methods of funding uncompensated and
18 undercompensated care.

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

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

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

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

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

1 (c) The Maryland Health Care Commission shall report its findings and
2 recommendations to the Governor and, in accordance with § 2-1246 of the State
3 Government Article, the General Assembly, on or before October 1, 2009.

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

6 SECTION 8. AND BE IT FURTHER ENACTED, That, except as provided in
7 Section 7 of this Act, this Act shall take effect July 1, 2007. Section 6 of this Act shall
8 remain effective for a period of 2 years and 6 months and, at the end of December 31,
9 2009, with no further action required by the General Assembly, Section 6 of this Act
10 shall be abrogated and of no further force and effect.