# SENATE BILL 175

J1 1lr0140
CF 1lr0141

By: **The President (By Request – Administration) and Senators Middleton, Benson, Forehand, Frosh, King, Klausmeier, Madaleno, Manno, Mathias, Montgomery, Pinsky, Ramirez, Raskin, and Rosapepe**
Introduced and read first time: January 24, 2011
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

**Maryland Health Quality and Cost Council**

FOR the purpose of establishing the Maryland Health Quality and Cost Council; providing for the membership of the Council; requiring the Council to meet a certain number of times each year; providing that a certain number of members of the Council constitutes a quorum; prohibiting members of the Council from receiving compensation, but entitling members to reimbursement for certain expenses; providing that members of the Council are subject to certain provisions of law; establishing the purposes of the Council; requiring the Council to avoid duplication of certain efforts; authorizing the Council to adopt certain policies and conduct certain activities; requiring the Council to submit a certain report to the Governor and the General Assembly on or before a certain date each year; defining certain terms; specifying the terms of the initial appointed members of the Council; and generally relating to the Maryland Health Quality and Cost Council.

BY adding to
Article – Health – General
Section 13–3001 through 13–3005 to be under the new subtitle "Subtitle 30. Maryland Health Quality and Cost Council"
Annotated Code of Maryland
(2009 Replacement Volume and 2010 Supplement)

Preamble

WHEREAS, Maryland has undertaken a serious and collaborative effort to enhance the quality of health care and reduce its costs through the work of the Health Quality and Cost Council established in 2007 by Governor Martin O'Malley's Executive Order 01.01.2007.24; and

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

WHEREAS, Since its inception, the Council has brought together private and public partners to build on existing quality and cost control efforts underway in the private sector; leverage grant opportunities from the federal government; and launch new initiatives to become a national leader in advancing evidence–based medicine, patient–centered medical homes, strategies to encourage wellness, prevention and chronic care management, and the reduction of healthcare–associated infections, and in other efforts to improve quality and control costs; and

WHEREAS, The federal Patient Protection and Affordable Care Act (ACA) offers an additional opportunity for states to address the urgent need to improve quality and rein in the runaway costs that threaten the long–term viability of our health care system; and

WHEREAS, Health economists and other experts agree that current health care spending in the United States is unsustainable; in 2009, the country spent on health care an estimated $2.5 trillion, or 17.3% of gross domestic product, with this amount likely to increase to 19.6% by 2019; and

WHEREAS, A 2010 study by the Commonwealth Fund shows that as Americans' per capita health care spending has increased at more than twice the rate of twelve other developed countries, our life expectancy has slipped further and further behind; and

WHEREAS, Another 2010 study assessing multiple measures of health care shows that despite spending more than twice as much per capita as six other developed countries, the United States scores last overall, and ranks last or near the bottom in safety, equity, efficiency, access to primary care, quality, and foregoing care because of cost; and

WHEREAS, Other indicators also make clear the need for quality improvements and cost control; for example, almost 100,000 Americans die each year from medical errors in hospitals, and patients receive only 55% of the care recommended for their health conditions; and

WHEREAS, Chronic illnesses, such as cardiovascular disease, cancer, and diabetes, are among the most prevalent, costly, and sometimes preventable health problems, accounting for 70% of all deaths and 75% of all health care costs; and

WHEREAS, While Maryland's health and quality rankings show significant strengths, they also suggest the need for improvement; and

WHEREAS, In the United Health Foundation's annual assessment of the health of state populations, Maryland is above average, ranking 21st overall and 20th in health determinants; the State ranks even higher on some specific indicators, placing 6th in smoking prevalence, 10th in immunization coverage, 2nd in per capita number of primary care physicians, 5th in percentage of children in poverty, 16th in self–reported health status, and 17th in cardiovascular disease; and

WHEREAS, Maryland in recent years also has made significant gains in certain areas, with rates of preventable hospitalizations, smoking prevalence, and cardiovascular and cancer deaths all decreasing markedly; and

WHEREAS, On other measures, Maryland ranks in the lower half of states, placing 33rd in health outcomes overall, 32nd in early prenatal care, 31st in premature deaths, 32nd in cardiovascular and cancer deaths, 34th in diabetes, 35th in geographic disparities, 41st in infant mortality, and 50th in infectious diseases; and

WHEREAS, Health disparities also persist in the State, with rates of diabetes, infant mortality, obesity, and other indicators varying by race and ethnicity, and disparities persisting for ten of the fourteen leading causes of death; and

WHEREAS, Maryland's implementation of the ACA is projected to reduce the number of the State's uninsured by half; and

WHEREAS, This coverage expansion will fall short of its potential to improve health without a dual focus on improvements in the quality of care afforded to both the current and newly insured; and

WHEREAS, Maryland's implementation of the ACA is also projected to save the State $829 million over the next 10 years; and

WHEREAS, These substantial savings will begin to reverse themselves at the end of the decade unless the State succeeds in bending the cost curve and significantly reducing growth in health care spending; and

WHEREAS, Maryland recognizes that achieving this imperative to improve health care quality and control costs will require sustained leadership, innovation, and coordination; and

WHEREAS, Maryland seeks to ensure that the Health Quality and Cost Council continues to provide this critical leadership and collaboration between the public and private sectors to promote better health and health care value; now, therefore,

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

**Article – Health – General**

**SUBTITLE 30. MARYLAND HEALTH QUALITY AND COST COUNCIL.**

**13–3001.**

**(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

**(B) "AFFORDABLE CARE ACT" MEANS THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, AND ANY REGULATIONS ADOPTED OR GUIDANCE ISSUED UNDER THE ACTS.**

**(C) "CARRIER" MEANS:**

**(1) AN INSURER AUTHORIZED TO SELL HEALTH INSURANCE;**

**(2) A NONPROFIT HEALTH SERVICE PLAN;**

**(3) A HEALTH MAINTENANCE ORGANIZATION; OR**

**(4) ANY OTHER ENTITY PROVIDING A PLAN OF HEALTH INSURANCE, HEALTH BENEFITS, OR HEALTH SERVICES AUTHORIZED UNDER THE INSURANCE ARTICLE OR THE AFFORDABLE CARE ACT.**

**(D) "COUNCIL" MEANS THE MARYLAND HEALTH QUALITY AND COST COUNCIL.**

**(E) "HEALTH INSURANCE" HAS THE MEANING STATED IN § 1–101 OF THE INSURANCE ARTICLE.**

**(F) "MARYLAND PATIENT SAFETY CENTER" MEANS THE NOT FOR PROFIT DESIGNATED BY THE MARYLAND HEALTH CARE COMMISSION AS THE PATIENT SAFETY ORGANIZATION OF THE STATE.**

**13–3002.**

**THERE IS A MARYLAND HEALTH QUALITY AND COST COUNCIL IN THE DEPARTMENT.**

**13–3003.**

**(A) THE COUNCIL CONSISTS OF THE FOLLOWING MEMBERS:**

**(1) THE SECRETARY; AND**

**(2) THIRTEEN MEMBERS APPOINTED BY THE GOVERNOR.**

**(B) AT LEAST TEN OF THE THIRTEEN MEMBERS APPOINTED BY THE GOVERNOR SHALL BE REPRESENTATIVE OF THE FOLLOWING:**

**(1) HEALTH INSURANCE CARRIERS;**

**(2) EMPLOYERS;**

**(3) HEALTH CARE PROVIDERS;**

**(4) HEALTH CARE CONSUMERS; AND**

**(5) EXPERTS IN HEALTH CARE QUALITY AND COST CONTAINMENT.**

**(C) TO THE EXTENT PRACTICABLE, THE COUNCIL'S COMPOSITION SHALL REFLECT:**

**(1) THE GENDER, RACIAL, AND ETHNIC DIVERSITY OF THE STATE; AND**

**(2) THE GEOGRAPHIC REGIONS OF THE STATE.**

**(D) TO THE EXTENT PRACTICABLE, MEMBERS OF THE COUNCIL SHALL:**

**(1) POSSESS A HIGH LEVEL OF EXPERTISE AND KNOWLEDGE IN THE PROFESSIONAL AREAS THEY REPRESENT; AND**

**(2) BE ACTIVE IN ONGOING HEALTH QUALITY AND COST CONTAINMENT EFFORTS IN THE STATE.**

**(E) (1) THE GOVERNOR SHALL APPOINT THE CHAIR OF THE COUNCIL.**

**(2) IF THE SECRETARY IS NOT THE CHAIR OF THE COUNCIL, THE GOVERNOR SHALL APPOINT THE SECRETARY TO BE THE CO–CHAIR OR THE VICE–CHAIR.**

**(F) (1) THE TERM OF A MEMBER APPOINTED BY THE GOVERNOR IS 3 YEARS.**

**(2) THE TERMS OF MEMBERS APPOINTED BY THE GOVERNOR ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS ON OCTOBER 1, 2011.**

**(3) AT THE END OF A TERM, A MEMBER CONTINUES TO SERVE UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.**

**(4) A MEMBER WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES ONLY FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.**

**(G) A MEMBER:**

**(1) MAY NOT SERVE MORE THAN TWO CONSECUTIVE FULL TERMS; AND**

**(2) SERVES AT THE PLEASURE OF THE GOVERNOR.**

**(H) (1) THE COUNCIL SHALL DETERMINE THE TIMES, PLACES, AND FREQUENCY OF ITS MEETINGS BUT SHALL MEET AT LEAST FOUR TIMES EACH YEAR.**

**(2) A MAJORITY OF THE MEMBERS OF THE COUNCIL CONSTITUTES A QUORUM.**

**(I) A MEMBER OF THE COUNCIL:**

**(1) MAY NOT RECEIVE COMPENSATION AS A MEMBER OF THE COUNCIL; BUT**

**(2) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.**

**(J) A MEMBER SHALL BE SUBJECT TO TITLE 15, SUBTITLES 1 THROUGH 7 OF THE STATE GOVERNMENT ARTICLE.**

**(K) THE SECRETARY SHALL DESIGNATE STAFF FOR THE COUNCIL.**

**13–3004.**

**(A) THE PURPOSES OF THE COUNCIL ARE TO:**

**(1) COORDINATE AND FACILITATE COLLABORATION ON HEALTH CARE QUALITY IMPROVEMENT AND COST CONTAINMENT INITIATIVES AMONG:**

**(I) MEDICAL GROUPS, HOSPITALS, AND OTHER HEALTH CARE PROVIDERS;**

**(II) HEALTH INSURANCE CARRIERS AND OTHER HEALTH CARE PURCHASERS;**

**(III) UNITS OF STATE AND LOCAL GOVERNMENT;**

**(IV) HEALTH CARE PROFESSIONAL BOARDS; AND**

**(V) ACADEMIC EXPERTS IN HEALTH CARE;**

**(2) MAKE RECOMMENDATIONS ON HEALTH CARE QUALITY AND COST CONTAINMENT PRIORITIES AND INITIATIVES TO:**

**(I) THE GOVERNOR AND GENERAL ASSEMBLY;**

**(II) OTHER UNITS OF STATE AND LOCAL GOVERNMENT, INDEPENDENT COMMISSIONS, AND POLICYMAKERS;**

**(III) HEALTH CARE PROFESSIONAL BOARDS;**

**(IV) THE MARYLAND PATIENT SAFETY CENTER;**

**(V) HEALTH CARE INDUSTRY GROUPS;**

**(VI) HEALTH CARE CONSUMERS; AND**

**(VII) OTHER PUBLIC AND PRIVATE STAKEHOLDERS;**

**(3) DEVELOP STRATEGIES TO IMPROVE THE QUALITY AND COST–EFFECTIVENESS OF CARE FOR INDIVIDUALS WITH CHRONIC ILLNESS OR AT RISK OF CHRONIC ILLNESS;**

**(4) SUPPORT ONGOING EFFORTS TO EXPAND THE USE OF HEALTH INFORMATION TECHNOLOGY IN HEALTH CARE SYSTEMS;**

**(5) EXPLORE STRATEGIES, INCLUDING FINANCIAL, PERFORMANCE–BASED INCENTIVES, TO REDUCE AND ELIMINATE HEALTH DISPARITIES, AND MAKE RECOMMENDATIONS REGARDING THE DEVELOPMENT AND IMPLEMENTATION OF THOSE STRATEGIES;**

**(6) SEEK TO LEVERAGE OPPORTUNITIES FOR DEMONSTRATION PROJECTS, FEDERAL GRANT FUNDING, AND OTHER INITIATIVES TO IMPROVE QUALITY AND CONTAIN COSTS MADE AVAILABLE BY THE AFFORDABLE CARE ACT;**

**(7) ASSESS OPTIONS AND MAKE RECOMMENDATIONS REGARDING STRATEGIES FOR COLLECTING AND DISSEMINATING PATIENT–CENTERED OUTCOMES RESEARCH TO PROMOTE EVIDENCE–BASED PRACTICES AMONG HEALTH CARE PROVIDERS IN THE STATE; AND**

**(8) EXAMINE AND MAKE RECOMMENDATIONS ON OTHER ISSUES RELATING GENERALLY TO THE MISSION OF THE COUNCIL TO IMPROVE HEALTH CARE QUALITY AND CONTAIN HEALTH CARE COSTS.**

**(B) THE COUNCIL SHALL AVOID DUPLICATION OF EXISTING HEALTH CARE QUALITY IMPROVEMENT AND COST CONTAINMENT EFFORTS IN THE STATE.**

**(C) THE COUNCIL MAY:**

**(1) ADOPT BYLAWS, RULES, POLICIES, OR PROCEDURES TO CONDUCT BUSINESS AND CARRY OUT THE PURPOSES OF THIS SUBTITLE;**

**(2) (I) ESTABLISH WORKGROUPS, COMMITTEES, OR TASK FORCES; AND**

**(II) DESIGNATE ADDITIONAL INDIVIDUALS WITH RELEVANT EXPERTISE TO SERVE ON THE WORKGROUPS, COMMITTEES, OR TASK FORCES; AND**

**(3) CONSULT WITH OTHER UNITS OF STATE AND LOCAL GOVERNMENT TO CARRY OUT THE DUTIES OF THE COUNCIL.**

**13–3005.**

**ON OR BEFORE JANUARY 1 OF EACH YEAR, THE COUNCIL SHALL SUBMIT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY, A REPORT THAT:**

**(1) DESCRIBES THE ACTIVITIES OF THE COUNCIL DURING THE YEAR, INCLUDING PERFORMANCE DATA WHERE APPLICABLE; AND**

**(2) MAKES FINDINGS AND RECOMMENDATIONS FOR IMPROVING HEALTH CARE QUALITY AND REDUCING HEALTH CARE COSTS IN THE STATE.**

SECTION 2. AND BE IT FURTHER ENACTED, That the terms of the initial appointed members of the Maryland Health Quality and Cost Council shall expire as follows:

(1) four members in 2012;

(2) four members in 2013; and

(3) five members in 2014.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2011.