SENATE BILL 1020

J3 7lr0515

By: **Senator Middleton**
Introduced and read first time: February 8, 2017
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Maryland Health Care Regulatory Reform Act of 2017

FOR the purpose of reorganizing the Maryland Health Care Commission and the Health Services Cost Review Commission to be the Maryland Health Care and Cost Review Commission; providing for the membership of the Commission; specifying the terms, appointment, qualifications, and compensation of members of the Commission; requiring each appointee to the Commission to take a certain oath before taking office; specifying the appointment and term of the chair of the Commission; specifying the appointment and term of the executive director of the Commission; requiring the Attorney General to be legal counsel to the Commission; authorizing the Commission to hire certain experts and delegate certain authority to a member or the staff of the Commission; repealing the Health Services Cost Review Commission, the Health Services Cost Review Commission Fund, and related provisions of law rendered obsolete by this Act; repealing provisions of law that relate to the Maryland Health Care Commission administration of the small group insurance market; transferring certain responsibilities relating to the Maryland Health Care Commission and the Health Services Cost Review Commission to the Commission; altering the limit on the total fees that may be assessed by the Commission on certain entities; renaming the Maryland Health Care Commission Fund to be the Maryland Health Care and Cost Review Commission Fund; requiring the Commission to submit a certain proposal to the Governor and the General Assembly by a certain date; providing for the transfer of the functions, powers, and duties of the Maryland Health Care Commission and the Health Services Cost Review Commission on a certain date; specifying the terms of the initial members of the Commission; providing for the transfer of certain employees to the Commission without diminution of certain rights, benefits, or employment or retirement status; providing for the termination of the terms of certain officials; providing for the transfer of certain records, credits, assets, liabilities, obligations, rights, privileges, and appropriations to the Commission on a certain date; providing for the continuity of the status of certain laws, regulations, standards, guidelines, policies, orders, directives, forms, plans, memberships, contracts, property, investigations, rights,

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

duties, and responsibilities; requiring the publisher of the Annotated Code of Maryland, in consultation with and subject to the approval of the Department of Legislative Services, to correct any cross–references or terminology rendered incorrect by this Act and to describe any corrections made in an editor's note following the section affected; making conforming changes; defining certain terms; altering certain definitions; and generally relating to the regulation of health care and health care facilities in the State.

BY repealing
Article – Health – General
Section 19–108.1; 19–201 through 19–208 and the part "Part I. Definitions; General Provisions"; and 19–213 and the subtitle "Subtitle 2. Health Services Cost Review Commission"
Annotated Code of Maryland
(2015 Replacement Volume and 2016 Supplement)

BY renumbering
Article – Health – General
Section 19–211, 19–212, 19–214, 19–214.1, 19–214.2, 19–214.3, and 19–215 through 19–227, respectively, and the part "Part II. Health Care Facility Rate Setting"
to be Section 19–150 through 19–168, respectively, and the part "Part VI. Health Care Facility Rate Setting"
Annotated Code of Maryland
(2015 Replacement Volume and 2016 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–101, 19–103 through 19–108, 19–109(b), 19–111, 19–130, 19–143(a) and (e), 19–144, 19–303(a) and (c), 19–325(a), (b), and (c), 19–326, 19–3A–03, 19–3A–07(c), 19–3A–08, 19–3B–04(b), 19–3B–05(e), 19–710.1(b), (h), and (k), 19–710.2(b), 19–711.3, 19–720, 19–906(c), and 19–1808(a)
Annotated Code of Maryland
(2015 Replacement Volume and 2016 Supplement)

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–102
Annotated Code of Maryland
(2015 Replacement Volume and 2016 Supplement)

BY adding to
Article – Health – General
Section 19–109(e) and (f)
Annotated Code of Maryland
(2015 Replacement Volume and 2016 Supplement)

BY repealing and reenacting, with amendments,

Article – Health – General
Section 19–155, 19–159, 19–161, and 19–163
Annotated Code of Maryland
(2015 Replacement Volume and 2016 Supplement)
(As enacted by Section 2 of this Act)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 19–108.1; 19–201 through 19–208 and the part "Part I. Definitions; General Provisions"; and 19–213 and the subtitle "Subtitle 2. Health Services Cost Review Commission" of Article – Health – General of the Annotated Code of Maryland be repealed.

SECTION 2. AND BE IT FURTHER ENACTED, That Section(s) 19–211, 19–212, 19–214, 19–214.1, 19–214.2, 19–214.3, and 19–215 through 19–227, respectively, and the part "Part II. Health Care Facility Rate Setting" of Article – Health – General of the Annotated Code of Maryland be renumbered to be Section(s) 19–150 through 19–168, respectively, and the part "Part VI. Health Care Facility Rate Setting".

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

Article – Health – General

19–101.

(A) In this subtitle**[**,**]** **THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

(B) "Commission" means the Maryland Health Care **AND COST REVIEW** Commission.

(C) "FACILITY" MEANS, WHETHER OPERATED FOR A PROFIT OR NOT:

(1) ANY HOSPITAL; OR

(2) ANY RELATED INSTITUTION.

(D) (1) "HOSPITAL SERVICES" MEANS:

(I) INPATIENT HOSPITAL SERVICES AS ENUMERATED IN MEDICARE REGULATION 42 C.F.R. § 409.10, AS AMENDED;

(II) EMERGENCY SERVICES, INCLUDING SERVICES PROVIDED AT A FREESTANDING MEDICAL FACILITY LICENSED UNDER SUBTITLE 3A OF THIS TITLE;

(III) OUTPATIENT SERVICES PROVIDED AT A HOSPITAL;

(IV) OUTPATIENT SERVICES, AS SPECIFIED BY THE COMMISSION IN REGULATION, PROVIDED AT A FREESTANDING MEDICAL FACILITY LICENSED UNDER SUBTITLE 3A OF THIS TITLE THAT HAS RECEIVED:

1. A CERTIFICATE OF NEED UNDER § 19–120(O)(1) OF THIS SUBTITLE; OR

2. AN EXEMPTION FROM OBTAINING A CERTIFICATE OF NEED UNDER § 19–120(O)(3) OF THIS SUBTITLE; OR

(V) IDENTIFIED PHYSICIAN SERVICES FOR WHICH A FACILITY HAS COMMISSION–APPROVED RATES ON JUNE 30, 1985.

(2) "HOSPITAL SERVICES" INCLUDES A HOSPITAL OUTPATIENT SERVICE:

(I) OF A HOSPITAL THAT, ON OR BEFORE JUNE 1, 2015, IS UNDER A MERGED ASSET HOSPITAL SYSTEM;

(II) THAT IS DESIGNATED AS A PART OF ANOTHER HOSPITAL UNDER THE SAME MERGED ASSET HOSPITAL SYSTEM TO MAKE IT POSSIBLE FOR THE HOSPITAL OUTPATIENT SERVICE TO PARTICIPATE IN THE 340B PROGRAM UNDER THE FEDERAL PUBLIC HEALTH SERVICE ACT; AND

(III) THAT COMPLIES WITH ALL FEDERAL REQUIREMENTS FOR THE 340B PROGRAM AND APPLICABLE PROVISIONS OF 42 C.F.R. § 413.65.

(3) "HOSPITAL SERVICES" DOES NOT INCLUDE:

(I) OUTPATIENT RENAL DIALYSIS SERVICES; OR

(II) OUTPATIENT SERVICES PROVIDED AT A LIMITED SERVICE HOSPITAL AS DEFINED IN § 19–301 OF THIS TITLE, EXCEPT FOR EMERGENCY SERVICES.

(E) (1) "RELATED INSTITUTION" MEANS AN INSTITUTION THAT IS LICENSED BY THE DEPARTMENT AS:

(I) A COMPREHENSIVE CARE FACILITY THAT IS CURRENTLY REGULATED BY THE COMMISSION; OR

(II) AN INTERMEDIATE CARE FACILITY–INTELLECTUAL DISABILITY.

(2) "RELATED INSTITUTION" INCLUDES ANY INSTITUTION IN PARAGRAPH (1) OF THIS SUBSECTION, AS RECLASSIFIED FROM TIME TO TIME BY LAW.

19–102.

(a) The General Assembly finds that the health care regulatory system in this State is a highly complex structure that needs to be constantly reevaluated and modified in order to better reflect and be more responsive to the ever changing health care environment and the needs of the citizens of this State.

(b) The purpose of this subtitle is to establish a streamlined health care regulatory system in this State in a manner such that a single State health policy can be better articulated, coordinated, and implemented in order to better serve the citizens of this State.

19–103.

(a) There is a Maryland Health Care **AND COST REVIEW** Commission.

(b) The Commission is an independent commission that functions in the Department.

(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**]**;

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by:

(i) Advocating policies and systems to promote the efficient delivery of and improved access to health care services; and

(ii) Enhancing the strengths of the current health care service delivery and regulatory system;

(3) Facilitate the public disclosure of medical claims data for the development of public policy;

(4) Establish and develop a medical care database on health care services

rendered by health care practitioners;

(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services;

(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan;

(7) Analyze the medical care database and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners;

(8) Ensure utilization of the medical care database as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

(9) Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland;

(10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors;

(11) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article;

(12) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors; and

(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.**]**

19–104.

(a) (1) The Commission shall consist of **[**15**]** **5** members appointed by the Governor with the advice and consent of the Senate.

[(2) Of the 15 members:

(i) Nine shall be individuals who do not have any connection with the management or policy of a health care provider or payor; and

(ii) Of the remaining six members:

1. Two shall be physicians;

2. Two shall be payors, as defined in § 19–132 of this subtitle;

3. One shall be a nursing home administrator in the State; and

4. One shall be a nonphysician health care practitioner.**]**

(2) EACH MEMBER SHALL HAVE RECOGNIZED KNOWLEDGE AND INTEREST IN HEALTH CARE, INCLUDING EXPERIENCE IN:

(I) HEALTH CARE REGULATION;

(II) HOSPITAL, HEALTH CARE FACILITY, OR HEALTH PLAN ADMINISTRATION;

(III) MEDICAL PROFESSIONS;

(IV) BUSINESS OR LEGAL PROFESSIONS; OR

(V) CONSUMER PROTECTION.

(3) EACH MEMBER SHALL BE A REGISTERED VOTER IN THE STATE.

(4) THE COMMISSION SHALL BE:

(I) BROADLY REPRESENTATIVE OF THE GEOGRAPHIC AND DEMOGRAPHIC DIVERSITY OF THE STATE AND THE PUBLIC; AND

(II) COMPOSED OF INDIVIDUALS WITH DIVERSE TRAINING AND EXPERIENCE IN HEALTH CARE.

(5) EACH MEMBER SHALL DEVOTE FULL TIME TO THE DUTIES OF OFFICE.

(b) (1) The term of a member is **[**4**] 5** years.

(2) The terms of members are staggered as required by the terms provided for members of the Commission on October 1, **[**1999**] 2017**.

(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.

(5) The Governor may remove a member for neglect of duty, incompetence, or misconduct.

[(6) A member may not serve more than two consecutive terms.**]**

[(c) When appointing members to the Commission, the Governor shall:

(1) Assure that:

(i) At least five members are residents of different counties with a population of 300,000 or more; and

(ii) At least three members are residents of different counties with a population of less than 300,000, of which at least:

1. One shall be a resident of the Eastern Shore;

2. One shall be a resident of Allegany County, Garrett County, Washington County, Carroll County, or Frederick County; and

3. One shall be a resident of Southern Maryland; and

(2) To the extent practicable, assure geographic balance and promote racial, ethnic, and gender diversity in the Commission's membership.**]**

(C) BEFORE TAKING OFFICE, EACH APPOINTEE TO THE COMMISSION SHALL TAKE THE OATH REQUIRED BY ARTICLE I, § 9 OF THE MARYLAND CONSTITUTION.

19–105.

(a) **[**The**] WITH THE ADVICE AND CONSENT OF THE SENATE, FROM AMONG THE MEMBERS OF THE COMMISSION, THE** Governor shall appoint the **[**chairman**] CHAIR** of the Commission.

(b) **(1)** The **[**chairman may appoint a vice chairman for the Commission**] TERM OF THE CHAIR IS 5 YEARS AND BEGINS ON OCTOBER 1**.

(2) AT THE END OF A TERM, THE CHAIR CONTINUES TO SERVE UNTIL A SUCCESSOR QUALIFIES.

(3) A CHAIR WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR QUALIFIES.

19–106.

(a) **(1)** With the approval of the Governor **AND THE ADVICE AND CONSENT OF THE SENATE**, the Commission shall appoint an executive director who shall be the chief administrative officer of the Commission.

(2) (I) THE TERM OF THE EXECUTIVE DIRECTOR IS 3 YEARS AND BEGINS ON OCTOBER 1.

(II) AT THE END OF A TERM, THE EXECUTIVE DIRECTOR CONTINUES TO SERVE UNTIL A SUCCESSOR QUALIFIES.

(b) The executive director, the deputy directors, and the principal section chiefs serve at the pleasure of the Commission.

(c) (1) The executive director, the deputy directors, and the principal section chiefs shall be executive service or management service employees.

(2) The Commission, in consultation with the Secretary, shall determine the appropriate job classification and, subject to the State budget, the compensation for the executive director, the deputy directors, and the principal section chiefs.

(d) Under the direction of the Commission, the executive director shall perform any duty or function that the Commission requires.

(E) THE ATTORNEY GENERAL SHALL PROVIDE LEGAL COUNSEL TO THE COMMISSION.

19–107.

(a) (1) A majority of the full authorized membership of the Commission is a quorum.

(2) The decision of the Commission shall be by a majority of the **[**quorum present and voting**]** **FULL AUTHORIZED MEMBERSHIP**.

(b) The Commission shall meet **[**at least six times each year,**]** at the times and places that it determines **AND CONSIDERS NECESSARY**.

(c) **(1)** **[**Each**]** **SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, EACH** member of the Commission is entitled to:

[(1)**]** **(I)** Compensation in accordance with the State budget; and

[(2)**]** **(II)** Reimbursement for expenses under the Standard State Travel

Regulations, as provided in the State budget.

(2) THE SALARY OF:

(I) THE CHAIR OF THE COMMISSION SHALL BE AT LEAST $40,000 A YEAR; AND

(II) EACH MEMBER SHALL BE AT LEAST $35,000 A YEAR.

(d) (1) The Commission may employ a staff in accordance with the State budget.

(2) The Commission, in consultation with the Secretary, may set the compensation of a Commission employee in a position that:

(i) Is unique to the Commission;

(ii) Requires specific skills or experience to perform the duties of the position; and

(iii) Does not require the employee to perform functions that are comparable to functions performed in other units of the Executive Branch of State government.

(3) The Secretary of Budget and Management, in consultation with the Secretary, shall determine the positions for which the Commission may set compensation under paragraph (2) of this subsection.

(E) (1) AS THE COMMISSION CONSIDERS NECESSARY, THE COMMISSION SHALL HIRE EXPERTS TO ASSIST IN THE REGULATION OF HEALTH CARE SERVICES AND FACILITIES AND THE REVIEW OF THE COST OF HEALTH CARE SERVICES IN THE STATE.

(2) THE COMMISSION MAY RETAIN ON A CASE–BY–CASE BASIS ADDITIONAL EXPERTS AS REQUIRED FOR A PARTICULAR MATTER.

(F) THE COMMISSION MAY DELEGATE TO A MEMBER OR THE STAFF OF THE COMMISSION THE AUTHORITY TO PERFORM AN ADMINISTRATIVE FUNCTION NECESSARY TO CARRY OUT A DUTY OF THE COMMISSION.

19–108.

(a) In addition to the duties set forth elsewhere in this subtitle, the Commission:

(1) Shall adopt regulations specifying the Comprehensive Standard Health Benefit Plan to apply under Title 15, Subtitle 12 of the Insurance Article; and

(2) On or before March 1, 2008, in consultation with the Department, shall propose regulations to**[**:

(i) Specify**]** **SPECIFY** the components of wellness benefits, offered under Title 15, Subtitle 12 of the Insurance Article, that include incentives or differential cost–sharing for employees based on their participation in wellness activities**[**; and

(ii) Require small employers receiving a subsidy of small employer health benefit plan premium contributions under Title 15, Subtitle 12A of the Insurance Article to agree to purchase a wellness benefit**]**.

(b) In carrying out its duties under this section, the Commission shall comply with the provisions of § 15–1207 **[**and Title 15, Subtitle 12A**]** of the Insurance Article.

19–109.

(b) In addition to the duties set forth elsewhere in this subtitle, the Commission shall:

(1) Adopt rules and regulations that relate to its meetings, minutes, and transactions;

(2) Keep minutes of each meeting;

(3) Prepare annually a budget proposal that includes the estimated income of the Commission and proposed expenses for its administration and operation;

(4) Beginning December 1, 2000, and each December 1 thereafter, submit to the Governor, the Secretary, and, subject to § 2–1246 of the State Government Article, the General Assembly an annual report on the operations and activities of the Commission during the preceding fiscal year, including:

(i) A copy of each summary, compilation, and supplementary report required by this subtitle; **[**and**]**

(II) A SUMMARY OF THE COMMISSION'S ROLE IN HOSPITAL QUALITY OF CARE ACTIVITIES, INCLUDING INFORMATION ABOUT THE STATUS OF ANY PAY–FOR–PERFORMANCE INITIATIVES; AND

[(ii)**] (III)** Any other fact, suggestion, or policy recommendation that the Commission considers necessary; **[**and**]**

(5) Except for confidential or privileged medical or patient information, make:

(i) Each report filed and each summary, compilation, and report required under this subtitle available for public inspection at the office of the Commission during regular business hours; and

(ii) Each summary, compilation, and report available to any other State agency on request**;**

(6) PERIODICALLY PARTICIPATE IN OR DO ANALYSES AND STUDIES THAT RELATE TO:

(I) HEALTH CARE COSTS;

(II) THE FINANCIAL STATUS OF ANY FACILITY; OR

(III) ANY OTHER APPROPRIATE MATTER;

(7) OVERSEE AND ADMINISTER THE MARYLAND TRAUMA PHYSICIAN SERVICES FUND;

(8) ANNUALLY PUBLISH EACH ACUTE CARE HOSPITAL'S SEVERITY–ADJUSTED AVERAGE CHARGE PER CASE FOR THE 15 MOST COMMON INPATIENT DIAGNOSIS–RELATED GROUPS;

(9) BEGINNING OCTOBER 1, 2017, AND, SUBJECT TO ITEM (10)(II) OF THIS SUBSECTION, EVERY 6 MONTHS THEREAFTER, SUBMIT TO THE GOVERNOR, THE SECRETARY, AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY AN UPDATE ON THE STATUS OF THE STATE'S COMPLIANCE WITH THE PROVISIONS OF MARYLAND'S ALL–PAYER MODEL CONTRACT, INCLUDING:

(I) THE STATE'S:

1. PERFORMANCE IN LIMITING INPATIENT AND OUTPATIENT HOSPITAL PER CAPITA COST GROWTH FOR ALL PAYORS TO A TREND BASED ON THE STATE'S 10–YEAR COMPOUND ANNUAL GROSS STATE PRODUCT;

2. PROGRESS TOWARD ACHIEVING AGGREGATE SAVINGS IN MEDICARE SPENDING IN THE STATE EQUAL TO OR GREATER THAN $330,000,000 OVER THE 5 YEARS OF THE CONTRACT, BASED ON LOWER INCREASES IN THE COST PER MEDICARE BENEFICIARY;

3. PERFORMANCE IN SHIFTING FROM A PER–CASE RATE SYSTEM TO A POPULATION–BASED REVENUE SYSTEM, WITH AT LEAST 80% OF HOSPITAL REVENUE SHIFTED TO GLOBAL BUDGETING;

4. PERFORMANCE IN REDUCING THE HOSPITAL READMISSION RATE AMONG MEDICARE BENEFICIARIES TO THE NATIONAL AVERAGE; AND

5. PROGRESS TOWARD ACHIEVING A CUMULATIVE REDUCTION IN THE STATE HOSPITAL–ACQUIRED CONDITIONS OF 30% OVER THE 5 YEARS OF THE CONTRACT;

(II) A SUMMARY OF THE WORK CONDUCTED, RECOMMENDATIONS MADE, AND COMMISSION ACTION ON RECOMMENDATIONS MADE BY THE FOLLOWING GROUPS CREATED TO PROVIDE TECHNICAL INPUT AND ADVICE ON IMPLEMENTATION OF MARYLAND'S ALL–PAYER MODEL CONTRACT:

1. PAYMENT MODELS WORKGROUP;

2. PHYSICIAN ALIGNMENT AND ENGAGEMENT WORKGROUP;

3. PERFORMANCE MEASUREMENT WORKGROUP;

4. DATA AND INFRASTRUCTURE WORKGROUP;

5. THE MARYLAND HEALTH CARE AND COST REVIEW ADVISORY COUNCIL; AND

6. ANY OTHER WORKGROUPS CREATED FOR THIS PURPOSE;

(III) ACTIONS APPROVED AND CONSIDERED BY THE COMMISSION TO PROMOTE ALTERNATIVE METHODS OF RATE DETERMINATION AND PAYMENT OF AN EXPERIMENTAL NATURE, AS AUTHORIZED UNDER § 19–160(C)(2) OF THIS SUBTITLE;

(IV) REPORTS SUBMITTED TO THE FEDERAL CENTER FOR MEDICARE AND MEDICAID INNOVATION RELATING TO THE ALL–PAYER MODEL CONTRACT; AND

(V) ANY KNOWN ADVERSE CONSEQUENCES THAT IMPLEMENTING THE ALL–PAYER MODEL CONTRACT HAS HAD ON THE STATE, INCLUDING CHANGES OR INDICATIONS OF CHANGES TO QUALITY OF OR ACCESS TO CARE, AND THE ACTIONS THE COMMISSION HAS TAKEN TO ADDRESS AND MITIGATE THE CONSEQUENCES; AND

(10) IF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES ISSUES A WARNING NOTICE RELATED TO A "TRIGGERING EVENT" AS DESCRIBED IN THE ALL–PAYER MODEL CONTRACT:

(I) PROVIDE WRITTEN NOTIFICATION TO THE GOVERNOR, THE SECRETARY, AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY WITHIN 15 DAYS AFTER THE ISSUANCE OF THE NOTICE; AND

(II) SUBMIT THE UPDATE REQUIRED UNDER ITEM (9) OF THIS SUBSECTION EVERY 3 MONTHS.

(E) (1) THE COMMISSION SHALL SET DEADLINES FOR THE FILING OF REPORTS REQUIRED UNDER THIS SUBTITLE.

(2) THE COMMISSION MAY ADOPT RULES OR REGULATIONS THAT IMPOSE PENALTIES FOR FAILURE TO FILE A REPORT AS REQUIRED.

(3) THE AMOUNT OF ANY PENALTY UNDER PARAGRAPH (2) OF THIS SUBSECTION MAY NOT BE INCLUDED IN THE COSTS OF A FACILITY IN REGULATING ITS RATES.

(F) EXCEPT FOR PRIVILEGED MEDICAL INFORMATION, THE COMMISSION SHALL MAKE:

(1) EACH REPORT FILED AND EACH SUMMARY, COMPILATION, AND REPORT REQUIRED UNDER THIS SUBTITLE AVAILABLE FOR PUBLIC INSPECTION AT THE OFFICE OF THE COMMISSION DURING REGULAR BUSINESS HOURS; AND

(2) EACH SUMMARY, COMPILATION, AND REPORT AVAILABLE TO ANY AGENCY ON REQUEST.

19–111.

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

(2) "Fund" means the Maryland Health Care **AND COST REVIEW** Commission Fund.

(3) "Health benefit plan" has the meaning stated in § 15–1201 of the Insurance Article.

(4) "Health care practitioner" means any individual who is licensed,

certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(5) "Nursing home" means a related institution that is classified as a nursing home.

(6) "Payor" means:

(i) A health insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in the State in accordance with this article or the Insurance Article; or

(ii) A health maintenance organization that holds a certificate of authority in the State.

(b) Subject to the provisions of subsection (d) of this section, the Commission shall assess a fee on:

(1) All hospitals;

(2) All nursing homes;

(3) All payors; and

(4) All health care practitioners.

(c) (1) The total fees assessed by the Commission may not exceed **[**$12,000,000**] $24,000,000**.

(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) 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.

(d) In determining assessments of the total fees, the Commission shall:

(1) Use a methodology that accounts for the portion of the Commission's workload attributable to each industry assessed; and

(2) Recalculate workload distribution every 4 years.

(e) (1) The fees assessed in accordance with this section on health care practitioners shall be:

(i) Included in the licensing fee paid to the health care practitioner's licensing board; and

(ii) Transferred by the health care practitioner's licensing board to the Commission on a quarterly basis.

(2) The Commission may adopt regulations that waive the fee assessed under this section for a specific class of health care practitioners.

(3) (i) Subject to subparagraph (ii) of this paragraph, the Commission shall adopt regulations to permit a waiver of the fee assessment requirements for certain health care practitioners.

(ii) In adopting regulations to permit a waiver of the fee assessment requirements for certain health care practitioners, the Commission shall:

1. Consider the hourly wages of the health care practitioners; and

2. Give preference to exempting health care practitioners with an average hourly wage substantially below that of other health care practitioners.

(f) (1) There is a Maryland Health Care **AND COST REVIEW** Commission Fund.

(2) The Fund is a special 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 shall be retained to the credit of the Fund.

(6) The Fund shall be subject to an audit by the Office of Legislative Audits as provided for in § 2–1220 of the State Government Article.

(7) This section may not be construed to prohibit the Fund from receiving funds from any other source.

(8) The Fund shall be used only to provide funding for the Commission and for the purposes authorized under this subtitle.

(g) The Commission shall:

(1) (i) Assess fees on payors in a manner that apportions the total amount of the fees to be assessed on payors under subsection (d)(1) of this section among each payor based on the ratio of each payor's total premiums written in the State for health benefit plans to the total written premiums of all payors written in the State; and

(ii) On or before June 30 of each year, assess each payor a fee in accordance with item (i) of this item;

(2) (i) Assess fees for each hospital equal to the sum of:

1. The amount equal to one–half of the total fees to be assessed on hospitals under subsection (d)(1) of this section times the ratio of admissions of the hospital to total admissions of all hospitals; and

2. The amount equal to one–half of the total fees to be assessed on hospitals under subsection (d)(1) of this section times the ratio of gross operating revenue of each hospital to total gross operating revenues of all hospitals;

(ii) Establish minimum and maximum assessments; and

(iii) On or before June 30 of each year, assess each hospital a fee in accordance with item (i) of this item; and

(3) (i) Assess fees for each nursing home equal to the sum of:

1. The amount equal to one–half of the total fees to be assessed on nursing homes under subsection (d)(1) of this section times the ratio of admissions of the nursing home to total admissions of all nursing homes; and

2. The amount equal to one–half of the total fees to be assessed on nursing homes under subsection (d)(1) of this section times the ratio of gross operating revenue of each nursing home to total gross operating revenues of all nursing homes;

(ii) Establish minimum and maximum assessments; and

(iii) On or before June 30 of each year, assess each nursing home a fee in accordance with item (i) of this item.

(h) (1) On or before September 1 of each year, each payor, hospital, and nursing home assessed under this section shall make payment to the Commission.

(2) The Commission shall make provisions for partial payments.

(i) Any bill not paid within 30 days of the payment due date may be subject to an interest penalty to be determined and collected by the Commission.

19–130.

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

(2) "Fund" means the Maryland Trauma Physician Services Fund.

(3) "Maryland Trauma Specialty Referral Centers" means:

(i) The Johns Hopkins Health System Burn Program;

(ii) The Eye Trauma Center at the Wilmer Eye Institute at The Johns Hopkins Hospital; and

(iii) The Curtis National Hand Center at Union Memorial Hospital.

(4) "Rehabilitation hospital" means a facility classified as a special rehabilitation hospital as described in § 19–307 of this title that is affiliated with a trauma center by common ownership.

(5) (i) "Trauma center" means a facility designated by the Maryland Institute for Emergency Medical Services Systems as:

1. The State primary adult resource center;

2. A Level I trauma center;

3. A Level II trauma center;

4. A Level III trauma center;

5. A pediatric trauma center; or

6. The Maryland Trauma Specialty Referral Centers.

(ii) "Trauma center" includes an out–of–state pediatric trauma center that has entered into an agreement with the Maryland Institute for Emergency Medical Services Systems.

(6) "Trauma physician" means a physician who provides care in a trauma center or in a rehabilitation hospital to trauma patients on the State trauma registry as defined by the Maryland Institute for Emergency Medical Services Systems.

(7) "Uncompensated care" means care provided by a trauma physician to a trauma patient on the State trauma registry who:

(i) Has no health insurance, including Medicare Part B coverage;

(ii) Is not eligible for medical assistance coverage; and

(iii) Has not paid the trauma physician for care provided by the trauma physician, after documented attempts by the trauma physician to collect payment.

(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.

(c) The Fund consists of motor vehicle registration surcharges paid into the Fund in accordance with § 13–954(b)(2) of the Transportation 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;

3. The cost incurred by a Level I trauma center or pediatric trauma center to maintain trauma surgeons, orthopedic surgeons, and neurosurgeons on–call when a post–graduate resident is attending in the trauma center 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. When a post–graduate resident is permitted to be in the trauma center, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for Level I trauma centers or pediatric trauma centers;

4. The cost incurred by a Maryland Trauma Specialty Referral Center to maintain trauma surgeons on–call in the specialty of the Center when a post–graduate resident is attending in the Center 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. When a post–graduate resident is permitted to be in the Center, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for a Maryland Trauma Specialty Referral Center; and

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

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

C. A Level I trauma center shall be eligible for a maximum of 4,380 hours of trauma on–call per year;

D. A pediatric trauma center shall be eligible for a maximum of 4,380 hours of trauma on–call per year; and

E. A Maryland Trauma Specialty Referral Center shall be eligible for a maximum of 2,190 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 100% of the Medicare payment for the service, minus any recoveries made by the trauma physician for the care;

(iv) The Commission**[**, in consultation with the Health Services Cost Review Commission,**]** may establish a payment rate for uncompensated care incurred by a trauma physician in providing trauma care to trauma patients on the State trauma registry that is above 100% of the Medicare payment for the service if:

1. The Commission determines that increasing the payment rate above 100% of the Medicare payment for the service will address an unmet need in the State trauma system; and

2. The Commission reports on its intention to increase the payment rate to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1246 of the State Government Article, at least 60 days before any adjustment to the rate; and

(v) The total reimbursement to emergency physicians from the Fund may not exceed $300,000 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) (1) Except as provided in paragraph (2) of this subsection and notwithstanding any other provision of law, expenditures from the Fund for costs incurred in any fiscal year may not exceed revenues of the Fund.

(2) (i) The Commission, in consultation with the **[**Health Services Cost Review Commission and the**]** Maryland Institute for Emergency Medical Services Systems, shall develop a process for the award of grants to Level II and Level III trauma centers in the State to be used for equipment primarily used in the delivery of trauma care.

(ii) 1. The Commission shall issue grants under this paragraph from any balance carried over to the Fund from prior fiscal years.

2. The total amount of grants awarded under this paragraph in a fiscal year may not exceed 10% of the balance remaining in the Fund at the end of the fiscal year immediately prior to the fiscal year in which grants are awarded.

(iii) The process developed by the Commission for the award of grants under this paragraph shall include:

1. Grant applications and review and selection criteria for the award of grants;

2. Review by the Commission, if necessary, for any project that exceeds certificate of need thresholds; and

3. Any other procedure determined necessary by the Commission.

(iv) Before awarding grants under this subsection in a fiscal year, the 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 process that the Commission has developed for awarding grants in that fiscal year.

(f) On or before 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.

19–143.

(a) (1) On or before October 1, 2009, the Commission **[**and the Health Services Cost Review Commission**]** shall designate a health information exchange for the State.

(2) The Secretary, to align funding opportunities with the purposes of this section and the development and effective operation of the State's health information exchange, may provide grants to the health information exchange designated under paragraph (1) of this subsection.

(e) The **[**Health Services Cost Review**]** Commission, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services, shall take the actions necessary to:

(1) Assure that hospitals in the State receive the payments provided under § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations; and

(2) Implement any changes in hospital rates required by the federal Centers for Medicare and Medicaid Services to ensure compliance with § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

19–144.

(a) To facilitate the use of Web–based technology for electronic advance directives, the **[**Maryland Health Care**]** Commission shall develop criteria for recognizing electronic advance directives services that are authorized to connect to the State–designated health information exchange.

(b) To be authorized to connect to the State–designated health information exchange, an electronic advance directives service shall:

(1) Be recognized by the **[**Maryland Health Care**]** Commission;

(2) Be established in accordance with the National Institute of Standards and Technology Special Publication 800–63–2: Electronic Authentication Guideline;

(3) Be responsible for all costs associated with connecting to the State–designated health information exchange; and

(4) Store electronic advance directives that are received by facsimile or other electronic means.

(c) The State–designated health information exchange may charge electronic advance directives services recognized by the **[**Maryland Health Care**]** Commission a fee for connecting to the State–designated health information exchange.

(d) The State–designated health information exchange shall ensure that electronic advance directives services do not have access to information stored on the State–designated health information exchange.

19–155.

(a) If a hospital knowingly violates any provision of **[**§ 19–214.1 or § 19–214.2**]** **§ 19–153 OR § 19–154** of this subtitle or any regulation adopted under this subtitle, the Commission may impose a fine not to exceed $50,000 per violation.

(b) Before imposing a fine, the Commission shall consider the appropriateness of the fine in relation to the severity of the violation.

19–159.

(a) The Commission shall require each facility to give the Commission information that:

(1) Concerns the total financial needs of the facility;

(2) Concerns its current and expected resources to meet its total financial needs;

(3) Includes the effect of any proposal made, under **[**Subtitle 1 of this title**]** **THIS SUBTITLE**, on comprehensive health planning; and

(4) Includes physician information sufficient to identify practice patterns of individual physicians across all facilities.

(b) The identities of individual physicians are confidential and are not discoverable or admissible in evidence in a civil or criminal proceeding, and may only be disclosed to the following:

(1) The utilization review committee of a Maryland hospital;

(2) The Medical and Chirurgical Faculty of the State of Maryland;

(3) The State Board of Physicians;

(4) The Office of Health Care Quality in the Department;

(5) The **[**Maryland Health Care**]** Commission; or

(6) An investigatory body under the State or federal government.

19–161.

(a) (1) To have the statistical information needed for rate review and approval, the Commission shall compile all relevant financial and accounting information.

(2) The information shall include:

(i) Necessary operating expenses;

(ii) Appropriate expenses that are incurred in providing services to patients who cannot or do not pay;

(iii) Incurred interest charges; and

(iv) Reasonable depreciation expenses that are based on the expected useful life of property or equipment.

(b) The Commission shall define, by regulation, the types and classes of charges that may not be changed, except as specified in **[**§ 19–222**] § 19–163** of this subtitle.

(c) The Commission shall obtain from each facility its current rate schedule and each later change in the schedule that the Commission requires.

(d) The Commission shall:

(1) Permit a nonprofit facility to charge reasonable rates that will permit the facility to provide, on a solvent basis, effective and efficient service that is in the public interest; and

(2) Permit a proprietary profit–making facility to charge reasonable rates that:

(i) Will permit the facility to provide effective and efficient service that is in the public interest; and

(ii) Based on the fair value of the property and investments that are related directly to the facility, include enough allowance for and provide a fair return to the owner of the facility.

(e) In the determination of reasonable rates for each facility, as specified in this section, the Commission shall take into account all of the cost of complying with recommendations made, under **[**Subtitle 1 of this title**] THIS SUBTITLE**, on comprehensive health planning.

(f) In reviewing rates or charges or considering a request for change in rates or charges, the Commission shall permit a facility to charge rates that, in the aggregate, will produce enough total revenue to enable the facility to meet reasonably each requirement specified in this section.

(g) Except as otherwise provided by law, in reviewing rates or charges or considering a request for changes in rates or charges, the Commission may not hold executive sessions.

19–163.

(a) (1) A facility may not change any rate schedule or charge of any type or class defined under **[**§ 19–220(b)**] § 19–161(B)** of this subtitle, unless the facility files with the Commission a written notice of the proposed change that is supported by any information that the facility considers appropriate.

(2) Unless the Commission orders otherwise in conformity to this section, a change in the rate schedule or charge is effective on the date that the notice specifies. That effective date shall be at least 30 days after the date on which the notice is filed.

(b) (1) Commission review of a proposed change may not exceed 150 days after the notice is filed.

(2) The Commission may hold a public hearing to consider the notice.

(3) If the Commission decides to hold a public hearing, the Commission:

(i) Within 65 days after the filing of the notice, shall set a place and date for the hearing; and

(ii) May suspend the effective date of any proposed change until 30 days after conclusion of the hearing.

(4) If the Commission suspends the effective date of a proposed change, the Commission shall give the facility a written statement of the reasons for the suspension.

(5) The Commission:

(i) May conduct the public hearing without complying with formal rules of evidence; and

(ii) Shall allow any interested party to introduce evidence that relates to the proposed change, including testimony by witnesses.

(c) (1) The Commission may permit a facility to change any rate or charge temporarily, if the Commission considers it to be in the public interest.

(2) An approved temporary change becomes effective immediately on filing.

(3) Under the review procedures of this section, the Commission promptly shall consider the reasonableness of the temporary change.

(d) If the Commission modifies a proposed change or approves only part of a proposed change, a facility, without losing its right to appeal the part of the Commission order that denies full approval of the proposed change, may:

(1) Charge its patients according to the decision of the Commission; and

(2) Accept any benefits under that decision.

(e) If a change in any rate or charge increase becomes effective because a final determination is delayed because of an appeal or otherwise, the Commission may order the facility:

(1) To keep a detailed and accurate account of:

(i) Funds received because of the change; and

(ii) The persons from whom these funds were collected; and

(2) As to any funds received because of a change that later is held excessive or unreasonable:

(i) To refund the funds with interest; or

(ii) If a refund of the funds is impracticable, to charge over and amortize the funds through a temporary decrease in charges or rates.

(f) A decision by the Commission on any contested change under this section shall comply with the Administrative Procedure Act and shall be only prospective in effect.

(g) (1) The **[**State Health Services Cost Review**]** Commission shall provide incentives for merger, consolidation, and conversion and for the implementation of the institution–specific plan developed in accordance with § 19–119 of this **[**title**]** **SUBTITLE**.

(2) Notwithstanding any of the provisions in this section, on notification of a merger or consolidation by 2 or more hospitals, the Commission shall review the rates of those hospitals that are directly involved in the merger or consolidation in accordance with the rate review and approval procedures provided in **[**§ 19–220**]** **§ 19–161** of this subtitle and the regulations of the Commission.

(3) The Commission may provide, as appropriate, for temporary adjustment of the rates of those hospitals that are directly involved in the merger or consolidation, closure, or delicensure in order to provide sufficient funds for an orderly transition. These funds may include:

(i) Allowances for those employees who are or would be displaced;

(ii) Allowances to permit a surviving institution in a merger to generate capital to convert a closed facility to an alternate use;

(iii) Any other closure costs as defined in § 10–340 of the Economic Development Article; or

(iv) Agreements to allow retention of a portion of the savings that result for a designated period of time.

19–303.

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

(2) "Commission" means the **MARYLAND** Health **[**Services**]** **CARE AND** Cost Review 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;

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

(vi) Financial or in–kind support of the Maryland Behavioral Health Crisis Response System.

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

(c) (1) Each nonprofit hospital shall submit an annual community benefit report to the **[**Health Services Cost Review**]** 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;

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

(vii) A description of the hospital's efforts to track and reduce health disparities in the community that the hospital serves.

19–325.

(a) If voluntary efforts to reduce excess capacity prove insufficient, as a last resort the Maryland Health Care **AND COST REVIEW** 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 **AND COST REVIEW** 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**]** **MARYLAND HEALTH CARE AND** Cost Review Commission **[**have**]** **HAS** petitioned for all of the beds of the hospital to be delicensed.

(c) The Maryland Health Care **AND COST REVIEW** Commission **[**and the Health Services Cost Review Commission are**]** **IS A** necessary **[**parties**]** **PARTY** to any proceeding

in accordance with this section.

19–326.

If a hospital voluntarily closes, merges, or is delicensed under § 19–325 of this subtitle, the Department of Commerce, in cooperation with the Maryland Health Care **AND COST REVIEW** Commission, shall assist the hospital and local community in identifying alternative uses for the hospital buildings or sites.

19–3A–03.

(a) The Department shall issue a license to a freestanding medical facility that:

(1) Meets the licensure requirements under this subtitle; and

(2) Receives a certificate of need or an exemption from obtaining a certificate of need from the Maryland Health Care **AND COST REVIEW** Commission under § 19–120 of this title.

(b) A freestanding medical facility that uses in its title or advertising the word "emergency" or other language indicating to the public that medical treatment for immediately life–threatening medical conditions exist at that facility shall be licensed by the Department before it may operate in this State.

(c) Notwithstanding subsection (a)(2) of this section, the Department may not require a freestanding medical facility pilot project to be approved by the Maryland Health Care **AND COST REVIEW** Commission as a condition of licensure.

19–3A–07.

(c) (1) A freestanding medical facility pilot project shall provide to the Maryland Health Care **AND COST REVIEW** Commission information, as specified by the Commission, on the configuration, location, operation, and utilization, including patient–level utilization, of the pilot project.

(2) A certificate of need is not required for a freestanding medical facility pilot project.

19–3A–08.

(a) This section applies to all payors subject to the rate–setting authority of the **[**Health Services**]** **MARYLAND HEALTH CARE AND** Cost Review Commission, including:

(1) Insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery individual, group, or blanket health insurance policies and contracts in the State;

(2) Managed care organizations, as defined in § 15–101 of this article; and

(3) The Maryland Medical Assistance Program established under Title 15, Subtitle 1 of this article.

(b) A payor subject to this section shall pay rates set by the **[**Health Services**]** **MARYLAND HEALTH CARE AND** Cost Review Commission under Subtitle **[**2**]** **1** of this title for hospital services provided at:

(1) A freestanding medical facility pilot project authorized under this subtitle prior to January 1, 2008; and

(2) A freestanding medical facility licensed under § 19–3A–03 of this subtitle.

19–3B–04.

(b) The application shall:

(1) Be on a form and accompanied by any supporting information that the Secretary requires, including documentation that the Maryland Health Care **AND COST REVIEW** Commission has determined that the freestanding ambulatory care facility either received a certificate of need or is exempt from certificate of need requirements; and

(2) Be signed and verified by the applicant.

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**]** **MARYLAND HEALTH CARE AND** Cost Review Commission; or

(2) The review and approval of new services or facilities by the Maryland Health Care **AND COST REVIEW** Commission.

19–710.1.

(b) 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:

(1) 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

(2) Shall pay the claim submitted by:

(i) A hospital at the rate approved by the **[**Health Services**]** **MARYLAND HEALTH CARE AND** Cost Review Commission;

(ii) A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:

1. 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

2. 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

(iii) Any other health care provider:

1. For an evaluation and management service, no less than the greater of:

A. 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with the health maintenance organization; or

B. 140% of the rate paid by Medicare, as published by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; and

2. For a service that is not an evaluation and management service, no less than 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, to a similarly licensed provider under written contract with the health maintenance organization for the same covered service.

(h) The Maryland Health Care **AND COST REVIEW** Commission annually shall review payments to health care providers to determine the compliance of health maintenance organizations with the requirements of this section and report its findings to the Maryland Insurance Administration.

(k) The Maryland Insurance Administration, in consultation with the Maryland

Health Care **AND COST REVIEW** Commission, shall adopt regulations to implement this section.

19–710.2.

(b) (1) If an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through a health maintenance organization, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another carrier to offer, a point–of–service option to the employer, association, or other private group arrangement in conjunction with the health maintenance organization as an additional benefit for an employee or individual, at the employee's or individual's option, to accept or reject.

(2) When a health maintenance organization is the sole delivery system offered to employees by an employer, the health maintenance organization:

(i) Shall offer the employer a point–of–service option for the individual employee to accept or reject;

(ii) May not impose a minimum participation level on the point–of–service option; and

(iii) As part of the group enrollment application, shall provide to each employer a disclosure statement for each point–of–service option offered that conforms to regulations, for the point–of–service option required under paragraph (1) of this subsection, adopted by**[**:

1. The Maryland Health Care Commission for the small group market; and

2. The**]** **THE** Maryland Insurance Administration for the **SMALL GROUP MARKET AND THE** non–small group market.

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 money provided by the health maintenance organization to a hospital, in accordance with regulations adopted by the **[**Health Services**]** **MARYLAND HEALTH CARE AND** 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.

19–720.

(a) The **[**State Health Services**]** **MARYLAND HEALTH CARE AND** Cost Review Commission promptly shall give the Commissioner and the Secretary any financial information that the Commission acquires about each facility that is:

(1) Under the jurisdiction of the Commission; and

(2) Subject to this subtitle.

(b) If requested by the Commissioner or the Secretary, the **[**State Health Services**]** **MARYLAND HEALTH CARE AND** Cost Review Commission shall provide any other information that the Commission is authorized to acquire about health maintenance organizations regulated under this subtitle.

19–906.

(c) (1) Except for a limited licensee, the applicant shall have a certificate of need, as required under Subtitle 1 of this title, for the hospice care program to be operated.

(2) The Secretary, in consultation with the Maryland Health Care **AND COST REVIEW** Commission, shall specify those jurisdictions in which a general hospice is authorized to provide home–based hospice services.

(3) A general hospice may not be licensed to provide home–based hospice services in a jurisdiction unless the general hospice or an entity acquired by the general hospice provided home–based hospice services to a patient in the jurisdiction during the 12–month period ending December 31, 2001.

(4) Notwithstanding paragraph (3) of this subsection:

(i) A general hospice may provide home–based hospice services to a specific patient outside of the jurisdictions in which the hospice is licensed if the Maryland Health Care **AND COST REVIEW** Commission approves the service provision; and

(ii) A general hospice that is a hospital–based hospice or that had an affiliation agreement before April 5, 2003 with a health care facility or health care system may serve patients immediately upon discharge from the hospital, health care facility, or health care system, regardless of the jurisdiction in which the patient resides.

(5) Upon the notification by the Maryland Health Care **AND COST REVIEW** Commission of the issuance of a certificate of need to a general hospice, the Secretary shall append to the general hospice license any additional jurisdictions in which the general hospice may provide home–based hospice services.

(6) The hospice care program to be operated and its medical director shall meet the requirements that the Secretary adopts under this subtitle.

19–1808.

(a) The Department, in consultation with the Maryland Health Care **AND COST REVIEW** Commission and stakeholders, including advocates, consumers, and providers of assisted living services, shall develop a standard assisted living program services disclosure statement.

SECTION 4. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care and Cost Review Commission propose for consideration by the General Assembly:

(1) a streamlined certificate of need process; and

(2) a list of health care facilities and services that currently require a certificate of need but would be suitable to remove from the certificate of need requirement.

(b) The Commission shall submit the proposal to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on January 1, 2018.

SECTION 5. AND BE IT FURTHER ENACTED, That the terms of the initial members of the Maryland Health Care and Cost Review Commission shall expire as follows:

(1) two members in 2020;

(2) two members in 2021; and

(3) one member in 2022.

SECTION 6. AND BE IT FURTHER ENACTED, That:

(a) (1) All appropriations, including State and federal funds, held by the Maryland Health Care Commission and the Health Services Cost Review Commission to carry out the functions, programs, and services transferred under this Act shall be transferred to the Maryland Health Care and Cost Review Commission on October 1, 2017.

(2) Funding for the services and programs under the Maryland Health Care Commission and the Health Services and Cost Review Commission shall be provided for the Maryland Health Care and Cost Review Commission in the fiscal 2019 State budget.

(b) On October 1, 2017, all of the functions, powers, duties, books and records (including electronic records), real and personal property, equipment, fixtures, assets, liabilities, obligations, credits, rights, and privileges of the Maryland Health Care Commission and the Health Services Cost Review Commission that are transferred under this Act shall be transferred to the Maryland Health Care and Cost Review Commission.

SECTION 7. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission and the Health Services Cost Review Commission are hereby abolished and the Maryland Health Care and Cost Review Commission created under this Act shall be the successor of the commissions.

SECTION 8. AND BE IT FURTHER ENACTED, That all employees of the Maryland Health Care Commission and the Health Services Cost Review Commission who are transferred to the Maryland Health Care and Cost Review Commission as a result of this Act shall be transferred without diminution of their rights, benefits, employment, or retirement status.

SECTION 9. AND BE IT FURTHER ENACTED, That, except as otherwise provided by law, all existing laws, regulations, proposed regulations, standards and guidelines, policies, orders and other directives, forms, plans, memberships, contracts, property, investigations, administrative and judicial responsibilities, rights to sue and be sued, and all other duties and responsibilities associated with the functions of the Maryland Health Care Commission and the Health Services Cost Review Commission that are the subject of this Act prior to the effective date of this Act shall continue under and, as appropriate, are legal and binding on the Maryland Health Care and Cost Review Commission until completed, withdrawn, canceled, modified, or otherwise changed under the law.

SECTION 10. AND BE IT FURTHER ENACTED, That:

(a) The terms of each member of the Maryland Health Care Commission shall expire on September 30, 2017.

(b) The terms of each member of the Health Services Cost Review Commission shall expire on September 30, 2017.

SECTION 11. 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. The publisher shall adequately describe any such correction in an editor's note following the section affected.

SECTION 12. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2017.