SENATE BILL 519

Unofficial Copy 1996 Regular Session
C3 6lr1678

By: Senator Dorman (Governor's Task Force on Community Health Networks)
Introduced and read first time: February 2, 1996
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 22, 1996

CHAPTER ____

AN ACT concerning

Community Health Networks

FOR the purpose of requiring community health networks to obtain a license from the Secretary of Health and Mental Hygiene and the State Insurance Commissioner prior to contracting with certain persons or offering health care services to enrollees; providing certain exceptions; providing for the purpose of this Act; specifying how certain persons may form a community health network; specifying how a community health network may operate under certain circumstances; specifying the requirements of a community health network under thisAct, including actuarial soundness requirements, hold harmless provisions, marketing provisions, and rate filing and contract provisions; specifying the duties and responsibilities of the Secretary and Commissioner under this Act; requiring the Secretary and the Commissioner to adopt certain regulations related to the regulation and operation of community health networks; requiring theSecretary to adopt by regulation a certain complaint system; requiring the Secretary and the Commissioner to adopt certain joint internal procedures; establishing certain penalties; altering a provision of law related to requirements of certain health insurers and other persons for accepting and rejecting certain providers for participation on certain provider panels to include a community health network; defining certain terms; altering a certain provision of law relatingto medical review committees for the purpose of including a community health network; providing for the application of this Act; and generally relating to the operationand regulation of community health networks.

BY repealing and reenacting, without amendments,
Article 48A - Insurance Code
Section 490CC(a)(1) and (b)
Annotated Code of Maryland

(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article 48A - Insurance Code
Section 490CC(a)(2)
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY adding to
Article - Health - General
Section 19-1801 through ~~19-1820~~ 19-1825, inclusive, to be under the new subtitle
"Subtitle 18. Community Health Networks"
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, without amendments,
Article - Health Occupations
Section 14-501(a)(1) and (3), (b), (c), and (d)
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article - Health Occupations
Section 14-501(a)(2)
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

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

Article 48A - Insurance Code

490CC.

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

(2) (i) "Carrier" means:

1. An insurer;

2. A nonprofit health service plan;

3. A health maintenance organization;

4. A dental plan organization; [or]

5. A COMMUNITY HEALTH NETWORK, AS DEFINED UNDER § 19-1801 OF THE HEALTH - GENERAL ARTICLE; OR

[5.] 6. Any other person or organization that provides health benefit plans subject to State regulation.

(ii) "Carrier" includes an entity that arranges a providerpanel for a carrier.

(b) A carrier that uses a provider panel shall establish procedures for:

(1) Reviewing applications for participation in the carrier's provider panel in accordance with the provisions of this section;

(2) Notifying an enrollee of:

(i) The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee; and

(ii) The right of an enrollee upon request to continue to receive health care services for a period of up to 90 days from the date of a primary care provider's notice of termination from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the provider;

(3) Notifying primary care providers in the carrier's provider panel of the termination of a specialty referral services provider; and

(4) Notifying a provider at least 90 days prior to the date of the termination of the provider for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the provider.

Article - Health - General

SUBTITLE 18. COMMUNITY HEALTH NETWORKS.

19-1801.

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

(B) "ADMINISTRATION" MEANS THE MARYLAND INSURANCE ADMINISTRATION.

(C) "COMMISSIONER" MEANS THE STATE INSURANCE COMMISSIONER.

(D) "COMMUNITY HEALTH NETWORK" MEANS AN ENTITY THAT:

(1) IS A LEGAL AGGREGATION OF HEALTH CARE PROVIDERS THAT IS OPERATING COLLECTIVELY AND LICENSED BY THE SECRETARY AND THE COMMISSIONER TO OPERATE FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES TO ENROLLEES GENERALLY ON A PREPAID BASIS OR FIXED PAYMENT PER TIME PERIOD;

(2) IS EITHER AN INCORPORATED ENTITY OR ACTS THROUGH A LICENSED ENTITY, SUCH AS A PARTNERSHIP, CORPORATION, OR SOLE PROPRIETORSHIP, THAT HAS AUTHORITY OVER THE ENTITY'S ACTIVITIES AND RESPONSIBILITY FOR SATISFYING THE REQUIREMENTS OF THIS SUBTITLE;

(3) PROVIDES OR ARRANGES FOR THE PROVISION OF~~:~~

~~(I)~~ A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES OR LESS THAN A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES; ~~OR~~

~~(II) HEALTH CARE SERVICES TO POPULATIONS WITH DISTINCT HEALTH NEEDS;~~ AND

(4) IS WILLING TO BE HELD CLINICALLY AND FISCALLY ACCOUNTABLE FOR THE HEALTH STATUS OF THE ENROLLEES SERVED BY MEETING THE QUALITY IMPROVEMENT AND FINANCIAL SOLVENCY REQUIREMENTS ESTABLISHED UNDER THIS SUBTITLE.

(E) "ENROLLEE" MEANS AN INDIVIDUAL, INCLUDING A MEMBER OF A GROUP, TO WHOM A COMMUNITY HEALTH NETWORK IS OBLIGATED TO PROVIDE HEALTH CARE SERVICES IN ACCORDANCE WITH THIS SUBTITLE.

(F) "HEALTH CARE PROVIDER" MEANS:

(1) AN INDIVIDUAL WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM; OR

(2) A HEALTH CARE FACILITY, AS DEFINED IN § 19-101 OF THIS TITLE, WHERE HEALTH CARE SERVICES ARE PROVIDED TO PATIENTS, INCLUDING AN OUTPATIENT CLINIC AND A MEDICAL LABORATORY.

(G) (1) "HEALTH CARE SERVICES" MEANS SERVICES, MEDICAL EQUIPMENT, AND SUPPLIES THAT ARE PROVIDED BY A PROVIDER.

(2) "HEALTH CARE SERVICES" INCLUDES:

(I) AMBULANCE SERVICES;

(II) APPLIANCES, DRUGS, MEDICINES, AND SUPPLIES;

(III) AUDIOLOGIC CARE AND SERVICES;

~~(III)~~ (IV) CHIROPRACTIC CARE AND SERVICES;

~~(IV)~~ (V) CONVALESCENT INSTITUTIONAL CARE;

~~(V)~~ (VI) DENTAL CARE AND SERVICES;

~~(VI)~~ (VII) EXTENDED CARE;

~~(VII)~~ (VIII) FAMILY PLANNING OR INFERTILITY SERVICES;

~~(VIII)~~ (IX) HEALTH EDUCATION SERVICES;

~~(IX)~~ (X) HOME HEALTH CARE OR MEDICAL SOCIAL SERVICES;

(XI) HOSPICE SERVICES;

~~(X)~~ (XII) INPATIENT HOSPITAL SERVICES;

~~(XI)~~ (XIII) LABORATORY, RADIOLOGICAL, OR OTHER DIAGNOSTIC SERVICES;

(XIV) MARRIAGE AND FAMILY THERAPY;

~~(XII)~~ (XV) MEDICAL CARE AND SERVICES;

(XVI) MEDICAL NUTRITION THERAPY;

~~(XIII)~~ (XVII) MENTAL HEALTH SERVICES;

~~(XIV)~~ (XVIII) NURSING CARE AND SERVICES;

~~(XV)~~ (XIX) NURSING HOME CARE;

~~(XVI)~~ (XX) OPTICAL CARE AND SERVICES;

~~(XVII)~~ (XXI) OPTOMETRIC CARE AND SERVICES;

~~(XVIII)~~ (XXII) OSTEOPATHIC CARE AND SERVICES;

~~(XIX)~~ (XXIII) OUTPATIENT SERVICES;

~~(XX)~~ (XXIV) PHARMACEUTICAL SERVICES;

~~(XXI)~~ (XXV) PHYSICAL THERAPY CARE AND SERVICES;

~~(XXII)~~ (XXVI) PODIATRIC CARE AND SERVICES;

~~(XXIII)~~ (XXVII) PREVENTIVE MEDICAL SERVICES;

~~(XXIV)~~ (XXVIII) PSYCHOLOGICAL CARE AND SERVICES;

~~(XXV)~~ (XXIX) REHABILITATIVE SERVICES;

(XXX) SPEECH PATHOLOGY SERVICES;

~~(XXVI)~~ (XXXI) SURGICAL CARE AND SERVICES;

~~(XXVII)~~ (XXXII) TREATMENT FOR ALCOHOLISM OR DRUG ABUSE; AND

~~(XXVIII)~~ (XXXIII) ANY OTHER CARE, SERVICE, OR TREATMENT OF DISEASE OR INJURY, THE CORRECTION OF DEFECTS, OR THE MAINTENANCE OF THE PHYSICAL AND MENTAL WELL-BEING OF HUMAN BEINGS.

(H) "PAYOR" MEANS:

(1) AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION THAT HOLDS A CERTIFICATE OF AUTHORITY TO OFFER HEALTH INSURANCE POLICIES OR CONTRACTS IN THE STATE IN ACCORDANCE WITH THIS ARTICLE OR ARTICLE 48A OF THE CODE; OR

(2) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

(I) (1) "PURCHASER" MEANS ANY PERSON WITH WHICH A COMMUNITY HEALTH NETWORK DIRECTLY CONTRACTS TO PROVIDE HEALTH CARE SERVICES.

(2) "PURCHASER" INCLUDES:

(I) AN INDIVIDUAL;

(II) AN EMPLOYER; OR

(III) ~~THE STATE~~ A GOVERNMENTAL ENTITY.

(J) "RISK-BEARING ENTITY" MEANS A COMMUNITY HEALTH NETWORK OR ENTITY THAT PARTICIPATES IN A COMMUNITY HEALTH NETWORK THAT BEARS ALL OF OR PART OF THE RISK OF LOSS.

19-1802.

THE PURPOSE OF THIS SUBTITLE IS TO:

(1) FOSTER THE DEVELOPMENT OF COMMUNITY HEALTH NETWORKS THAT WILL BE RESPONSIBLE FOR ARRANGING FOR OR DELIVERING TO A DEFINED POPULATION ON AN INSURED, PREPAID, OR FIXED PRICE BASIS AN ARRAY OF HEALTH CARE SERVICES FROM ROUTINE PRIMARY AND PREVENTIVE CARE TO ACUTE INPATIENT HOSPITAL CARE;

(2) ENCOURAGE THE FORMATION OF COMMUNITY HEALTH NETWORKS BY DIVERSE GROUPS WITH A VIEW TOWARD ACHIEVING GREATER EFFICIENCY AND ECONOMY IN PROVIDING HEALTH CARE SERVICES;

(3) ENCOURAGE THE FORMATION OF COMMUNITY HEALTH NETWORKS THAT INCLUDE HEALTH CARE PROVIDERS THAT HAVE HISTORICALLY PROVIDED HEALTH CARE SERVICES IN THE COMMUNITY;

~~(3)~~ (4) PROVIDE ONE OVERALL STATE LAW THAT:

(I) REGULATES COMMUNITY HEALTH NETWORKS;

(II) ALLOWS FLEXIBILITY FOR THE MANY FORMS THAT COMMUNITY HEALTH NETWORKS MAY TAKE; AND

(III) FACILITATES PUBLIC UNDERSTANDING AND UNIFORM ADMINISTRATION OF THE REGULATIONS ADOPTED UNDER THIS SUBTITLE; AND

~~(4)~~ (5) PROVIDE FOR THE REGULATION OF:

(I) THE QUALITY AND PUBLIC ACCOUNTABILITY OF HEALTH CARE SERVICES PROVIDED BY COMMUNITY HEALTH NETWORKS, BY THE DEPARTMENT; AND

(II) ALL OTHER MATTERS COVERED UNDER THIS SUBTITLE, INCLUDING RESERVES AND FINANCIAL SOLVENCY REQUIREMENTS, BY THE COMMISSIONER.

19-1803.

THIS SUBTITLE DOES NOT APPLY TO A COMMUNITY HEALTH NETWORK THAT:

(1) IS CONTRACTING DIRECTLY WITH A PURCHASER UNDER A FEE FOR SERVICE OR OTHER NONRISK BEARING ARRANGEMENT; OR

(2) IS CONTRACTING DIRECTLY UNDER A CAPITATED OR OTHER RISK-SHARING ARRANGEMENT WITH A PAYOR OR ~~THE STATE~~ A GOVERNMENTAL ENTITY WHERE THE PAYOR OR ~~THE STATE~~ A GOVERNMENTAL ENTITY IS ASSUMING ALL OF THE FINANCIAL RISK OF PROVIDING HEALTH CARE SERVICES TO ENROLLEES ~~AND THE COMMUNITY HEALTH NETWORK IS NOT A RISK-BEARING ENTITY~~.

19-1804.

(A) A COMMUNITY HEALTH NETWORK MAY BE FORMED, EITHER SINGLY OR IN SOME COMBINATION BY:

(1) HEALTH CARE PROVIDERS;

(2) INSURERS;

(3) NONPROFIT HEALTH SERVICE PLANS;

(4) HEALTH MAINTENANCE ORGANIZATIONS;

(5) EMPLOYERS; OR

(6) ANY OTHER BUSINESS OR LEGAL ENTITIES.

~~(B) A COMMUNITY HEALTH NETWORK MAY:~~

~~(1) OFFER A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES OR OFFER LESS THAN A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES PROVIDED THE COMMUNITY HEALTH NETWORK THAT OFFERS LESS THAN A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES DISCLOSES TO ANY PRESENT OR POTENTIAL ENROLLEE OR PURCHASER WHAT SERVICES WILL BE OFFERED AND SPECIFICALLY STATES THAT A FULL RANGE OF SERVICES IS NOT BEING OFFERED AND THE COMMUNITY HEALTH NETWORK IS NOT AVOIDING RISK; AND~~

~~(2)~~ (B) (1) A COMMUNITY HEALTH NETWORK MAY PROVIDE A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES TO SPECIAL POPULATIONS DIRECTLY OR INDIRECTLY THROUGH CONTRACTUAL ARRANGEMENTS WITH ENTITIES IF THE POPULATION SELECTION IS NOT DESIGNED TO AVOID RISK, BUT RATHER TO MAKE AVAILABLE SPECIALIZED HEALTH CARE PROVIDERS AND SERVICES FOR GROUPS WITH DISTINCT HEALTH NEEDS.

(2) A COMMUNITY HEALTH NETWORK IS SUBJECT TO ARTICLE 48A, § 699(B) OF THE CODE.

19-1805.

(A) EACH COMMUNITY HEALTH NETWORK SHALL ESTABLISH A WRITTEN QUALITY IMPROVEMENT PLAN TO ASSURE THE CONTINUING DELIVERY OF QUALITY HEALTH CARE SERVICES TO ENROLLEES.

(B) THE QUALITY IMPROVEMENT PLAN SHALL:

(1) IDENTIFY THE COMMUNITY HEALTH NETWORK'S HEALTH CARE PRIORITIES AND OBJECTIVES, INCLUDING A DESCRIPTION OF HOW THESE PRIORITIES AND OBJECTIVES THAT RELATE TO THE HEALTH STATUS PROBLEMS AND NEEDS OF ITS ENROLLEES WILL BE PROVIDED FOR;

(2) ESTABLISH AN ONGOING PROCESS FOR ENSURING THAT HEALTH CARE PROVIDERS ARE APPROPRIATELY CREDENTIALED AND THAT HEALTH CARE SERVICES ARE COORDINATED AND PROVIDED TO ENROLLEES IN A TIMELY MANNER;

(3) ESTABLISH PROCEDURES FOR WORKING WITH OTHER EXISTING HEALTH BENEFIT PLANS, LOCAL HEALTH DEPARTMENTS, <u>HEALTH CARE PROVIDERS THAT HAVE HISTORICALLY PROVIDED HEALTH CARE SERVICES WITHIN THE COMMUNITY,</u> AND COMMUNITY ORGANIZATIONS SERVING THE SAME COMMUNITY TO DEVELOP AND IMPLEMENT A PROCESS FOR IMPROVING THE HEALTH STATUS OF THE COMMUNITY; AND

(4) DESCRIBE HOW INFORMATION FROM ANNUAL REPORTS, CONSUMER COMPLAINTS, AND ANY OTHER SOURCE WILL BE USED TO IMPROVE THE QUALITY OF HEALTH CARE SERVICES PROVIDED BY THE COMMUNITY HEALTH NETWORK.

(C) (1) UNLESS THE COMMUNITY HEALTH NETWORK RECEIVES A WAIVER FROM THE DEPARTMENT, THE DEPARTMENT SHALL REVIEW AND APPROVE THE QUALITY IMPROVEMENT PLAN OF EACH COMMUNITY HEALTH NETWORK EVERY 2 YEARS.

(2) THE SECRETARY SHALL ESTABLISH BY REGULATION THE CRITERIA TO BE USED TO DETERMINE IF THE REVIEW OF A COMMUNITY HEALTH NETWORK'S QUALITY IMPROVEMENT PLAN MAY BE WAIVED.

19-1806.

(A) IN ADDITION TO THE REQUIREMENTS OF § 19-1805 OF THIS SUBTITLE, ANNUALLY, EACH COMMUNITY HEALTH NETWORK SHALL:

(1) WORKING IN CONCERT WITH LOCAL HEALTH DEPARTMENTS AND OTHER APPROPRIATE COMMUNITY ORGANIZATIONS, IDENTIFY SPECIFIC HEALTH PROBLEMS IN THE COMMUNITY IT SERVES;

(2) DEVELOP AN ACTION PLAN THAT IS RESPONSIVE TO AT LEAST ONE OF THE HEALTH PROBLEMS IDENTIFIED THAT INCLUDES:

(I) MEASURABLE OBJECTIVES TO BE ACHIEVED WITHIN A SPECIFIED TIME PERIOD;

(II) WHAT RESOURCES WILL BE USED TO ACHIEVE THE HEALTH OBJECTIVES IDENTIFIED IN THE ACTION PLAN; AND

(III) A PROCESS FOR MEASURING THE RESULTS OF THE ACTION PLAN AND EVALUATING THE RESULTS TO DETERMINE FUTURE GOALS AND OBJECTIVES; AND

(3) PREPARE AND SUBMIT ANNUALLY TO THE SECRETARY A PROGRESS REPORT THAT CONTAINS SPECIFIC OUTCOME MEASUREMENTS THAT MARK ITS PROGRESS IN ADDRESSING:

(I) HEALTH CARE PROBLEMS WITHIN ITS SERVICE AREA AND THE STATE IN GENERAL; AND

(II) HEALTH PRIORITIES AND OBJECTIVES IN THE COMMUNITY.

(B) IN ADDITION TO SUBSECTION (A) OF THIS SECTION, EACH COMMUNITY HEALTH NETWORK SHALL:

(1) REPORT ANY FINANCIAL OR OTHER INFORMATION REQUIRED BY THE COMMISSIONER BY REGULATION FOR THE PURPOSE OF EVALUATING WHETHER THE COMMUNITY HEALTH NETWORK IS OPERATING IN A FISCALLY SOUND MANNER AND REASONABLENESS OF ITS RATES;

(2) PARTICIPATE IN APPROPRIATE QUALITY OF CARE AND PERFORMANCE MEASUREMENT DATA COLLECTION EFFORTS OF THE HEALTH CARE ACCESS AND COST COMMISSION;

(3) REPORT INFORMATION CONSISTENT WITH THE REQUIREMENTS OF THE MARYLAND MEDICAL CARE DATA BASE ESTABLISHED UNDER § 19-1507 OF THIS TITLE; AND

(4) FOR A COMMUNITY HEALTH NETWORK WITH A PARTICIPATING HOSPITAL, COMPLY WITH THE DATA REPORTING REQUIREMENTS OF THE HEALTH SERVICES COST REVIEW COMMISSION FOR THE PURPOSE OF EVALUATING ANY FIXED PRICE PROSPECTIVE PAYMENT ARRANGEMENTS FOR COMPLIANCE WITH THE REQUIREMENTS OF SUBTITLE 2 OF THIS TITLE.

19-1807.

EACH COMMUNITY HEALTH NETWORK SHALL PROVIDE TO ANY PERSON DURING ANY OPEN ENROLLMENT PERIOD AND, AT LEAST ANNUALLY, TO EACH ENROLLEE WRITTEN MATERIALS THAT INCLUDE IN CLEAR AND CONCISE TERMS THE FOLLOWING INFORMATION:

(1) ANY COPAYMENT, COINSURANCE, OR DEDUCTIBLE REQUIREMENTS THAT AN ENROLLEE OR THE ENROLLEE'S FAMILY MAY INCUR IN OBTAINING COVERAGE AND HEALTH CARE SERVICES UNDER THE COMMUNITY HEALTH NETWORK'S HEALTH BENEFIT PLAN;

(2) THE HEALTH CARE BENEFITS TO WHICH THE ENROLLEE IS ENTITLED;

(3) AN ANNUALLY UPDATED LIST OF ADDRESSES AND TELEPHONE NUMBERS OF PROVIDERS PARTICIPATING IN THE COMMUNITY HEALTH NETWORK;

(4) WHERE AND IN WHAT MANNER AN ENROLLEE MAY OBTAIN HEALTH CARE SERVICES, INCLUDING PROCEDURES FOR SELECTING OR CHANGING PRIMARY CARE PHYSICIANS AND THE LOCATIONS OF HOSPITALS AND OUTPATIENT TREATMENT CENTERS THAT ARE UNDER CONTRACT WITH THE COMMUNITY HEALTH NETWORK TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES;

(5) ANY LIMITATIONS OF THE HEALTH CARE SERVICES, KINDS OF SERVICES, BENEFITS, AND EXCLUSIONS THAT APPLY TO THE HEALTH BENEFIT PLAN; AND

(6) GRIEVANCE AND COMPLAINT PROCEDURES FOR CLAIM OR TREATMENT DENIALS, DISSATISFACTION WITH CARE, AND ACCESS TO CARE ISSUES.

19-1808.

(A) EACH COMMUNITY HEALTH NETWORK SHALL ESTABLISH AND MAINTAIN A USER-FRIENDLY ENROLLEE COMPLAINT SYSTEM.

(B) THE COMPLAINT SYSTEM SHALL INCLUDE:

(1) REASONABLE PROCEDURES FOR THE RESOLUTION OF COMPLAINTS INITIATED BY ENROLLEES CONCERNING THE PROVISION OF HEALTH CARE SERVICES; AND

(2) A DISCLOSURE THAT IF A COMPLAINT IS NOT SATISFIED TO THE SATISFACTION OF THE ENROLLEE, THE ENROLLEE MAY CONTACT THE DEPARTMENT IN ACCORDANCE WITH § 19-1814 OF THIS SUBTITLE.

19-1809.

(A) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE, A COMMUNITY HEALTH NETWORK SHALL BE LICENSED JOINTLY BY THE SECRETARY AND THE COMMISSIONER TO OPERATE AS A COMMUNITY HEALTH NETWORK BEFORE IT MAY:

(1) ISSUE ANY CONTRACT OR CERTIFICATE TO A PURCHASER;

(2) PROVIDE HEALTH CARE SERVICES TO ENROLLEES; OR

(3) OTHERWISE OPERATE IN THE STATE.

(B) THE SECRETARY AND THE COMMISSIONER SHALL ISSUE A LICENSE TO AN APPLICANT THAT MEETS THE REQUIREMENTS OF THIS SUBTITLE AND ALL APPLICABLE REGULATIONS ADOPTED BY THE SECRETARY OR THE COMMISSIONER UNDER THIS SUBTITLE.

(C) A LICENSE ISSUED UNDER THIS SUBTITLE IS NOT TRANSFERABLE.

19-1810.

(A) AN APPLICANT FOR A LICENSE TO OPERATE AS A COMMUNITY HEALTH NETWORK SHALL:

(1) SUBMIT AN APPLICATION TO THE SECRETARY;

(2) PAY TO THE SECRETARY THE APPLICATION FEE SET BY THE SECRETARY BY REGULATION; AND

(3) PAY TO THE COMMISSIONER AN APPLICATION REVIEW FEE SET BY THE COMMISSIONER BY REGULATION.

(B) THE APPLICATION SHALL:

(1) BE ON A FORM AND ACCOMPANIED BY THE SUPPORTING INFORMATION THAT THE SECRETARY AND THE COMMISSIONER REQUIRE UNDER SUBSECTION (C) OF THIS SECTION; AND

(2) BE SIGNED AND VERIFIED BY THE APPLICANT.

(C) THE APPLICATION SHALL BE ACCOMPANIED BY:

(1) A COPY OF THE BASIC COMMUNITY HEALTH NETWORK ORGANIZATIONAL DOCUMENT AND ANY AMENDMENTS TO IT THAT, WHERE APPLICABLE, ARE CERTIFIED BY THE DEPARTMENT OF ASSESSMENTS AND TAXATION;

(2) A COPY OF THE BYLAWS OF THE COMMUNITY HEALTH NETWORK, IF ANY, THAT ARE CERTIFIED BY THE APPROPRIATE OFFICER;

(3) A LIST OF THE INDIVIDUALS WHO ARE TO BE RESPONSIBLE FOR THE CONDUCT OF THE AFFAIRS OF THE COMMUNITY HEALTH NETWORK, INCLUDING ALL MEMBERS OF THE GOVERNING BODY, THE OFFICERS AND DIRECTORS IF IT IS A CORPORATION, AND THE PARTNERS OR ASSOCIATES IF IT IS A PARTNERSHIP OR ASSOCIATION;

(4) THE ADDRESSES OF THOSE INDIVIDUALS AND THEIR OFFICIAL CAPACITY WITH THE COMMUNITY HEALTH NETWORK;

(5) A STATEMENT BY EACH INDIVIDUAL REFERRED TO IN ITEM (3) OF THIS SUBSECTION THAT FULLY DISCLOSES THE EXTENT AND NATURE OF ANY CONTRACT OR ARRANGEMENT BETWEEN THE INDIVIDUAL AND THE COMMUNITY HEALTH NETWORK AND ANY POSSIBLE CONFLICT OF INTEREST;

(6) IF APPLICABLE, A RESUME OF THE QUALIFICATIONS OF:

(I) THE ADMINISTRATOR;

(II) THE MEDICAL DIRECTOR;

(III) THE ENROLLMENT DIRECTOR; AND

(IV) ANY OTHER INDIVIDUAL WHO IS ASSOCIATED WITH THE COMMUNITY HEALTH NETWORK THAT THE COMMISSIONER AND THE SECRETARY REQUEST UNDER THEIR JOINT INTERNAL PROCEDURES;

(7) A STATEMENT THAT DESCRIBES GENERALLY:

(I) THE COMMUNITY HEALTH NETWORK, INCLUDING:

1. ITS OPERATIONS;

2. ITS ENROLLMENT PROCESS;

3. ITS QUALITY ASSURANCE MECHANISM; AND

4. ITS INTERNAL GRIEVANCE PROCEDURES;

(II) THE METHODS THE COMMUNITY HEALTH NETWORK PROPOSES TO USE TO OFFER ITS ENROLLEES AND PUBLIC REPRESENTATIVES AN OPPORTUNITY TO PARTICIPATE IN MATTERS OF POLICY AND OPERATION;

(III) THE LOCATION OF THE FACILITIES WHERE HEALTH CARE SERVICES WILL BE AVAILABLE REGULARLY TO ENROLLEES;

(IV) THE TYPE AND SPECIALTY OF PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE ENGAGED TO PROVIDE HEALTH CARE SERVICES;

(V) THE NUMBER OF PHYSICIANS AND PERSONNEL IN EACH CATEGORY; AND

(VI) THE HEALTH AND MEDICAL RECORDS SYSTEM TO PROVIDE DOCUMENTATION OF USE BY ENROLLEES;

(8) THE FORM OF EACH CONTRACT THAT THE COMMUNITY HEALTH NETWORK PROPOSES TO OFFER TO PURCHASERS SHOWING THE BENEFITS TO WHICH THEY ARE ENTITLED AND A TABLE OF THE RATES CHARGED OR PROPOSED TO BE CHARGED FOR EACH FORM OF CONTRACT;

(9) A STATEMENT THAT DESCRIBES WITH REASONABLE CERTAINTY EACH GEOGRAPHIC AREA TO BE SERVED BY THE COMMUNITY HEALTH NETWORK;

(10) A STATEMENT OF THE FINANCIAL CONDITION OF THE COMMUNITY HEALTH NETWORK, INCLUDING:

(I) SOURCES OF FINANCIAL SUPPORT;

(II) A BALANCE SHEET SHOWING ASSETS, LIABILITIES, AND MINIMUM TANGIBLE NET WORTH; AND

(III) ANY OTHER FINANCIAL INFORMATION THE COMMISSIONER REQUIRES FOR ADEQUATE FINANCIAL EVALUATION;

(11) COPIES OF ANY PROPOSED ADVERTISING AND PROPOSED TECHNIQUES AND METHODS OF SELLING THE SERVICES OF THE COMMUNITY HEALTH NETWORK;

(12) A POWER OF ATTORNEY THAT IS EXECUTED BY THE COMMUNITY HEALTH NETWORK APPOINTING THE COMMISSIONER AS AGENT OF THE ORGANIZATION IN THIS STATE TO ACCEPT SERVICE OF PROCESS IN ANY ACTION, PROCEEDING, OR CAUSE OF ACTION ARISING IN THIS STATE AGAINST THE COMMUNITY HEALTH NETWORK;

(13) COPIES OF THE AGREEMENTS PROPOSED TO BE MADE BETWEEN THE COMMUNITY HEALTH NETWORK AND HEALTH CARE PROVIDERS; AND

(14) ANY OTHER DOCUMENT THAT THE SECRETARY OR THE COMMISSIONER MAY REQUIRE.

19-1811.

(A) A LICENSE EXPIRES ON THE SECOND ANNIVERSARY OF ITS EFFECTIVE DATE UNLESS THE LICENSE IS RENEWED FOR A 2-YEAR TERM AS PROVIDED IN THIS SECTION.

(B) BEFORE THE LICENSE EXPIRES, A LICENSE MAY BE RENEWED FOR AN ADDITIONAL 2-YEAR TERM, IF THE APPLICANT:

(1) OTHERWISE IS ENTITLED TO BE LICENSED;

(2) PAYS TO THE SECRETARY THE RENEWAL FEE SET BY THE SECRETARY BY REGULATION;

(3) PAYS TO THE COMMISSIONER THE RENEWAL REVIEW FEE SET BY THE COMMISSIONER BY REGULATION; AND

(4) SUBMITS TO THE SECRETARY:

(I) A RENEWAL APPLICATION ON THE FORM THAT THE SECRETARY AND COMMISSIONER REQUIRE; AND

(II) SATISFACTORY EVIDENCE OF COMPLIANCE WITH ANY REQUIREMENT UNDER THIS SUBTITLE FOR LICENSE RENEWAL.

(C) THE SECRETARY AND COMMISSIONER SHALL RENEW THE LICENSE IF THE APPLICANT MEETS THE REQUIREMENTS OF THIS SECTION.

(D) THE SECRETARY AND THE COMMISSIONER SHALL SET REASONABLE APPLICATION, APPLICATION REVIEW, LICENSE RENEWAL, AND RENEWAL REVIEW FEES NOT TO EXCEED THE ADMINISTRATIVE COST OF THE LICENSING PROGRAM AND THE COST TO THE SECRETARY AND THE COMMISSIONER FOR CARRYING OUT THEIR RESPONSIBILITIES UNDER THIS SUBTITLE.

(E) A LICENSE DOES NOT ENTITLE THE LICENSEE TO AN EXEMPTION FROM OTHER PROVISIONS OF LAW RELATING TO:

(1) THE REVIEW AND APPROVAL OF HOSPITAL RATES AND CHARGES BY THE HEALTH SERVICES COST REVIEW COMMISSION; AND

(2) THE REVIEW AND APPROVAL OF NEW SERVICES OR FACILITIES BY THE HEALTH RESOURCES PLANNING COMMISSION.

(F) SUBSECTION (E)(1) OF THIS SECTION DOES NOT PROHIBIT A LICENSED COMMUNITY HEALTH NETWORK THAT INCLUDES A HOSPITAL FROM NEGOTIATING A CAPITATION ARRANGEMENT OR PREMIUM FOR THE ENTIRE COMMUNITY HEALTH NETWORK IF THE HOSPITAL CAPITATION ARRANGEMENT HAS BEEN REVIEWED AND APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION.

19-1812.

(A) AFTER RECEIPT OF AN INITIAL APPLICATION FOR A LICENSE OR AN APPLICATION FOR RENEWAL OF A LICENSE UNDER § 19-1810 OR § 19-1811 OF THIS SUBTITLE, THE SECRETARY SHALL FORWARD THE APPLICATION AND THE SUPPORTING INFORMATION TO THE COMMISSIONER FOR REVIEW.

(B) DURING A REVIEW OF THE APPLICATION AND THE ACCOMPANYING INFORMATION, THE COMMISSIONER SHALL DETERMINE ~~IF THE APPLICANT IS A RISK-BEARING ENTITY AND~~ THE LEVEL OF RISK UNDERTAKEN OR PROPOSED TO BE UNDERTAKEN BY THE APPLICANT IN ORDER TO DETERMINE IF THE APPLICANT:

(1) SATISFIES THE FINANCIAL SOLVENCY REQUIREMENTS FOR LICENSURE FOR THE LEVEL OF RISK ASSUMED IN ACCORDANCE WITH § 19-1815 OF THIS SUBTITLE AND REGULATIONS ADOPTED BY THE COMMISSIONER UNDER THIS SUBTITLE; OR

(2) MAY BE WAIVED FROM HAVING TO SATISFY SOME OF THE REQUIREMENTS FOR LICENSURE UNDER THIS SUBTITLE~~; OR~~

~~(3) MAY BE WAIVED FROM HAVING TO BE LICENSED UNDER THIS SUBTITLE~~.

(C) IN DETERMINING, UNDER § 19-1815 OF THIS SUBTITLE, THE APPROPRIATE LEVEL OF FINANCIAL SOLVENCY FOR AN APPLICANT THAT IS A RISK-BEARING ENTITY, THE COMMISSIONER SHALL CONSIDER ~~IF THE APPLICANT:~~:

(1) ~~IS CONTRACTING DIRECTLY WITH PURCHASERS AND~~ THE TYPE OF PURCHASERS WITH WHICH ~~IT~~ THE APPLICANT IS CONTRACTING;

(2) WHETHER THE APPLICANT HAS ESTABLISHED OR IS ESTABLISHING A BUDGET TO PAY FOR HEALTH CARE SERVICES PROVIDED TO ENROLLEES; AND

(3) WHETHER THE APPLICANT IS LIABLE FOR ADDITIONAL EXPENSES ABOVE THE BUDGETED AMOUNT UP TO A NEGOTIATED PERCENTAGE.

(D) AFTER REVIEW, THE SECRETARY AND THE COMMISSIONER SHALL:

(1) APPROVE THE APPLICANT FOR A LICENSE;

(2) APPROVE THE APPLICANT FOR A LICENSE, BUT WAIVE SPECIFIED LICENSING REQUIREMENTS; OR

(3) DENY THE APPLICANT A LICENSE WITH THE REASONS FOR DENIAL INCLUDED IN THE DENIAL~~; OR~~

~~(4) WAIVE THE APPLICANT FROM HAVING TO OBTAIN A LICENSE UNDER THIS SUBTITLE~~.

19-1813.

(A) THE SECRETARY AND THE COMMISSIONER MAY DENY A LICENSE TO ANY APPLICANT, OR SUSPEND, RESTRICT, OR REVOKE A LICENSE IF THE APPLICANT

DOES NOT MEET THE REQUIREMENTS OF THIS SUBTITLE OR ANY REGULATIONS THAT ARE ADOPTED UNDER THIS SUBTITLE.

(B) (1) BEFORE DENYING, SUSPENDING, RESTRICTING, OR REVOKING A LICENSE UNDER THIS SUBTITLE, THE SECRETARY AND THE COMMISSIONER SHALL PROVIDE THE APPLICANT OR LICENSEE AN OPPORTUNITY FOR A HEARING.

(2) THE SECRETARY AND THE COMMISSIONER SHALL SEND A HEARING NOTICE TO ANY APPLICANT OR LICENSEE BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED, AT LEAST 30 DAYS BEFORE THE HEARING.

19-1814.

(A) THE DEPARTMENT IS THE SINGLE POINT OF ENTRY FOR A COMMUNITY HEALTH NETWORK IN OBTAINING A LICENSE TO OPERATE IN THE STATE AND FOR ENROLLEES AND OTHER PERSONS TO MAKE COMPLAINTS CONCERNING THE OPERATION OF A COMMUNITY HEALTH NETWORK.

(B) (1) THE SECRETARY SHALL:

(I) INVESTIGATE COMPLAINTS CONCERNING THE COMPLIANCE OF A COMMUNITY HEALTH NETWORK WITH THE REQUIREMENTS OF THIS SUBTITLE AND REGULATIONS ADOPTED UNDER THIS SUBTITLE REGARDING QUALITY OF CARE AND PUBLIC ACCOUNTABILITY ISSUES; AND

(II) REFER COMPLAINTS REGARDING FINANCIAL SOLVENCY, MARKET CONDUCT, BENEFITS, AND PUBLIC UNDERSTANDING ISSUES TO THE COMMISSIONER FOR INVESTIGATION.

(2) (I) THE SECRETARY SHALL ESTABLISH BY REGULATION A COMPLAINT SYSTEM FOR THE RECEIPT AND TIMELY INVESTIGATION OF COMPLAINTS.

(II) THE COMPLAINT SYSTEM SHALL INCLUDE:

1. A PROCEDURE FOR THE TIMELY ACKNOWLEDGMENT OF THE RECEIPT OF A COMPLAINT, INCLUDING ENROLLEE COMPLAINTS; AND

2. A PROCEDURE FOR FORWARDING TO THE COMMISSIONER COMPLAINTS CONCERNING FINANCIAL SOLVENCY, MARKET CONDUCT, BENEFITS, AND PUBLIC UNDERSTANDING ISSUES.

(3) IF A COMPLAINT CONCERNS A HEALTH CARE PROVIDER PERFORMANCE OR STANDARDS OF MEDICAL PRACTICE, THE SECRETARY SHALL REFER THE COMPLAINT TO THE BOARD THAT LICENSES, CERTIFIES, OR OTHERWISE AUTHORIZES THAT HEALTH CARE PROVIDER UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES.

(C) THE COMMISSIONER IS RESPONSIBLE FOR:

(1) DETERMINING WHETHER EACH COMMUNITY HEALTH NETWORK IS OR WILL BE ABLE TO PROVIDE A FISCALLY SOUND OPERATION AND ADEQUATE PROVISIONS AGAINST RISK OF INSOLVENCY AND MAY ADOPT REGULATIONS DESIGNED TO ACHIEVE THIS GOAL;

(2) ACTUARIAL AND FINANCIAL EVALUATIONS AND DETERMINATIONS AND RATE REVIEW OF EACH COMMUNITY HEALTH NETWORK; AND

(3) MONITORING THE MARKET CONDUCT ACTIVITIES OF COMMUNITY HEALTH NETWORKS TO AVOID MISREPRESENTATIONS AND CONFUSION AS TO COVERAGE AND BENEFITS BEING OFFERED.

19-1815.

(A) (1) A COMMUNITY HEALTH NETWORK SHALL BE ACTUARIALLY SOUND.

(2) THE SURPLUS THAT THE COMMUNITY HEALTH NETWORK IS REQUIRED TO HAVE SHALL BE PAID IN FULL.

(B) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, THE COMMISSIONER SHALL REQUIRE A COMMUNITY HEALTH NETWORK TO MAINTAIN A SURPLUS APPROPRIATE FOR THE LEVEL OF RISK THAT THE COMMUNITY HEALTH NETWORK UNDERTAKES OR PROPOSES TO UNDERTAKE.

(2) (I) THE SURPLUS REQUIRED UNDER THIS SUBSECTION SHALL EXCEED THE LIABILITIES OF THE COMMUNITY HEALTH NETWORK BY AT LEAST $500,000.

(II) THE COMMISSIONER MAY NOT REQUIRE A COMMUNITY HEALTH NETWORK TO MAINTAIN A SURPLUS IN EXCESS OF A VALUE OF $3,000,000.

(C) (1) FOR THE PROTECTION OF THE COMMUNITY HEALTH NETWORK'S ENROLLEES AND CREDITORS, THE APPLICANT SHALL DEPOSIT AND MAINTAIN IN TRUST WITH THE STATE TREASURER $100,000 IN CASH OR GOVERNMENT SECURITIES OF THE TYPE DESCRIBED IN ARTICLE 48A, § 110 OF THE CODE.

(2) (I) THE DEPOSITS SHALL BE ACCEPTED AND HELD IN TRUST BY THE STATE TREASURER IN ACCORDANCE WITH THE PROVISIONS OF ARTICLE 48A, §§ 108 THROUGH 118 OF THE CODE.

(II) FOR THE PURPOSE OF APPLYING THIS PARAGRAPH, A COMMUNITY HEALTH NETWORK SHALL BE TREATED AS AN INSURER.

(D) THE PROCEDURES FOR OFFERING HEALTH CARE SERVICES AND OFFERING AND TERMINATING CONTRACTS TO ENROLLEES MAY NOT DISCRIMINATE UNFAIRLY ON THE BASIS OF AGE, SEX, RACE, HEALTH, OR ECONOMIC STATUS. THIS REQUIREMENT DOES NOT PROHIBIT:

(1) REASONABLE UNDERWRITING CLASSIFICATIONS FOR ESTABLISHING CONTRACT RATES; OR

(2) EXPERIENCE RATING.

(E) (1) THE TERMS OF THE AGREEMENTS BETWEEN A COMMUNITY HEALTH NETWORK AND PROVIDERS OF HEALTH CARE SERVICES SHALL CONTAIN A "HOLD HARMLESS" CLAUSE.

(2) THE HOLD HARMLESS CLAUSE SHALL PROVIDE THAT THE HEALTH CARE PROVIDER MAY NOT, UNDER ANY CIRCUMSTANCES, INCLUDING

NONPAYMENT OF MONEYS DUE THE PROVIDERS BY THE COMMUNITY HEALTH NETWORK, INSOLVENCY OF THE COMMUNITY HEALTH NETWORK, OR BREACH OF THE PROVIDER CONTRACT, BILL, CHARGE, COLLECT A DEPOSIT, SEEK COMPENSATION, REMUNERATION, OR REIMBURSEMENT FROM, OR HAVE ANY RECOURSE AGAINST THE ENROLLEE, PATIENT, OR ANY PERSONS OTHER THAN THE COMMUNITY HEALTH NETWORK ACTING ON THEIR BEHALF, FOR HEALTH CARE SERVICES PROVIDED IN ACCORDANCE WITH THE PROVIDER CONTRACT.

(3) COLLECTION FROM THE ENROLLEE OF COPAYMENTS OR SUPPLEMENTAL CHARGES IN ACCORDANCE WITH THE TERMS OF THE ENROLLEE'S CONTRACT WITH THE COMMUNITY HEALTH NETWORK, OR CHARGES FOR HEALTH CARE SERVICES NOT COVERED UNDER THE ENROLLEE'S CONTRACT, MAY BE EXCLUDED FROM THE HOLD HARMLESS CLAUSE.

(4) EACH PROVIDER CONTRACT SHALL STATE THAT THE HOLD HARMLESS CLAUSE WILL SURVIVE THE TERMINATION OF THE PROVIDER CONTRACT, REGARDLESS OF THE CAUSE OF TERMINATION.

(F) THE COMMUNITY HEALTH NETWORK SHALL PROVIDE EVIDENCE OF ADEQUATE INSURANCE COVERAGE OR AN ADEQUATE PLAN FOR SELF-INSURANCE TO SATISFY CLAIMS FOR INJURIES THAT MAY OCCUR FROM PROVIDING HEALTH CARE SERVICES.

(G) (1) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, AN ENROLLEE OF A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE MAY NOT BE LIABLE TO A HEALTH CARE PROVIDER FOR A COVERED HEALTH CARE SERVICE PROVIDED TO THE ENROLLEE.

(2) (I) A HEALTH CARE PROVIDER OR A REPRESENTATIVE OF A HEALTH CARE PROVIDER MAY NOT COLLECT OR ATTEMPT TO COLLECT FROM AN ENROLLEE MONEY OWED TO THE HEALTH CARE PROVIDER BY A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE.

(II) A HEALTH CARE PROVIDER OR A REPRESENTATIVE OF A HEALTH CARE PROVIDER MAY NOT MAINTAIN AN ACTION AGAINST AN ENROLLEE TO COLLECT OR ATTEMPT TO COLLECT MONEY OWED TO THE HEALTH CARE PROVIDER BY A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE.

(3) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SUBSECTION, A HEALTH CARE PROVIDER OR REPRESENTATIVE OF A HEALTH CARE PROVIDER MAY COLLECT OR ATTEMPT TO COLLECT FROM AN ENROLLEE:

(I) COPAYMENT OR COINSURANCE SUMS OWED BY THE ENROLLEE TO A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE FOR COVERED HEALTH CARE SERVICES PROVIDED BY THE HEALTH CARE PROVIDER; OR

(II) PAYMENT OR CHARGES FOR HEALTH CARE SERVICES NOT COVERED UNDER THE ENROLLEE'S CONTRACT.

(H) (1) THE COMMISSIONER SHALL REQUIRE EACH COMMUNITY HEALTH NETWORK TO HAVE AN INSOLVENCY PLAN THAT PROVIDES FOR:

(I) CONTINUATION OF BENEFITS TO ENROLLEES FOR THE DURATION OF THE CONTRACT PERIOD FOR WHICH PREMIUMS HAVE BEEN PAID; AND

(II) CONTINUATION OF BENEFITS TO ENROLLEES WHO ARE ADMITTED TO AN INPATIENT HEALTH CARE FACILITY ON THE DATE OF INSOLVENCY UNTIL THE EARLIER OF:

1. THE DISCHARGE OF THE ENROLLEE FROM THE INPATIENT HEALTH CARE FACILITY; OR

2. 365 DAYS.

(2) IN DETERMINING THE ADEQUACY OF AN INSOLVENCY PLAN, THE COMMISSIONER MAY CONSIDER:

(I) THE EXISTENCE OF INSURANCE TO COVER EXPENSES INCURRED IN CONTINUING BENEFITS AFTER AN INSOLVENCY;

(II) PROVISIONS IN PROVIDER CONTRACTS OBLIGATING PROVIDERS TO CONTINUE TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES:

1. FOR THE DURATION OF THE CONTRACT PERIOD FOR WHICH PREMIUMS HAVE BEEN MADE; AND

2. IF ADMITTED TO AN INPATIENT HEALTH CARE FACILITY, UNTIL THE ENROLLEE IS DISCHARGED OR 365 DAYS, WHICHEVER OCCURS FIRST;

(III) RESERVES;

(IV) LETTERS OF CREDIT;

(V) GUARANTEES; OR

(VI) ANY OTHER ARRANGEMENT TO ASSURE THAT BENEFITS ARE CONTINUED IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH (1) OF THIS SUBSECTION.

(I) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, A HOSPITAL EMERGENCY FACILITY MAY COLLECT OR ATTEMPT TO COLLECT PAYMENT FROM AN ENROLLEE FOR HEALTH CARE SERVICES PROVIDED TO THAT ENROLLEE FOR A MEDICAL CONDITION THAT IS DETERMINED NOT TO BE AN EMERGENCY AS DEFINED IN § 19-701(D) OF THIS TITLE.

19-1816.

(A) EACH COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER, BEFORE THEY BECOME EFFECTIVE:

(1) ALL RATES THAT THE COMMUNITY HEALTH NETWORK CHARGES ENROLLEES OR GROUPS OF ENROLLEES; AND

(2) THE FORM AND CONTENT OF EACH CONTRACT BETWEEN THE COMMUNITY HEALTH NETWORK AND ITS ENROLLEES OR GROUPS OF ENROLLEES.

(B) RATES OF A COMMUNITY HEALTH NETWORK MAY NOT BE EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY IN RELATION TO THE SERVICES OFFERED.

(C) (1) IF, AT ANY TIME, A COMMUNITY HEALTH NETWORK WISHES TO AMEND A CONTRACT WITH ITS ENROLLEES OR CHANGE A RATE CHARGED, THE COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER THE NUMBER OF COPIES OF THE AMENDMENT OR RATE CHANGE THAT THE COMMISSIONER REQUIRES.

(2) THE COMMISSIONER SHALL PROVIDE THE DEPARTMENT WITH THE NUMBER OF COPIES IT REQUIRES.

(D) UNLESS THE COMMISSIONER DISAPPROVES A FILING UNDER THIS SECTION, THE FILING BECOMES EFFECTIVE 60 DAYS AFTER THE OFFICE OF THE COMMISSIONER RECEIVES THE FILING OR ON ANOTHER DATE THAT THE COMMISSIONER SETS.

19-1817.

EACH MARKETING DOCUMENT THAT SETS FORTH THE HEALTH CARE SERVICES OF A COMMUNITY HEALTH NETWORK SHALL DESCRIBE FULLY AND CLEARLY:

(1) THE HEALTH CARE SERVICES UNDER EACH BENEFIT PACKAGE AND EVERY OTHER BENEFIT TO WHICH AN ENROLLEE IS ENTITLED;

(2) WHERE AND HOW HEALTH CARE SERVICES MAY BE OBTAINED;

(3) EACH EXCLUSION OR LIMITATION ON ANY HEALTH CARE SERVICE OR OTHER BENEFIT THAT IT PROVIDES;

(4) EACH DEDUCTIBLE FEATURE;

(5) EACH COPAYMENT PROVISION; AND

(6) ALL INFORMATION REQUIRED BY ARTICLE 48A, § 703(C) OF THE CODE.

19-1818.

(A) THE COMMISSIONER OR AN AGENT OF THE COMMISSIONER SHALL EXAMINE THE FINANCIAL AFFAIRS AND STATUS OF EACH COMMUNITY HEALTH NETWORK AT LEAST ONCE EVERY 3 YEARS.

(B) (1) IN AN EXAMINATION UNDER SUBSECTION (A) OF THIS SECTION, THE OFFICERS AND EMPLOYEES OF THE COMMUNITY HEALTH NETWORK SHALL:

(I) COOPERATE WITH AND HELP THE COMMISSIONER AND ITS AGENTS; AND

(II) GIVE THEM CONVENIENT ACCESS TO ALL BOOKS, RECORDS, PAPERS, AND DOCUMENTS THAT RELATE TO THE BUSINESS OF THE COMMUNITY

HEALTH NETWORK, INCLUDING FINANCIAL RECORDS OF HEALTH CARE PROVIDERS THAT PROVIDE HEALTH CARE SERVICES UNDER CONTRACT.

(2) (I) THE COMMISSIONER MAY EMPLOY EXPERTS, NOT OTHERWISE A PART OF THE STAFF OF THE COMMISSIONER, TO CONDUCT AN EXAMINATION MADE UNDER THIS SECTION AT THE EXPENSE OF THE COMMUNITY HEALTH NETWORK.

(II) AN EXPERT EMPLOYED UNDER THIS PARAGRAPH MAY REWRITE, POST, OR BALANCE THE ACCOUNTS OF A COMMUNITY HEALTH NETWORK BEING EXAMINED.

(C) THE COMMISSIONER MAY EXAMINE UNDER OATH ANY OFFICER, AGENT, EMPLOYEE, OR ENROLLEE OF THE COMMUNITY HEALTH NETWORK, OR ANY OTHER PERSON WHO HAS OR EVER HAD ANY RELATION TO ITS AFFAIRS, TRANSACTIONS, OR FINANCIAL CONDITIONS.

19-1819.

(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION AND UNLESS, FOR GOOD CAUSE SHOWN, THE COMMISSIONER EXTENDS THE TIME FOR A REASONABLE PERIOD:

(1) ON OR BEFORE MARCH 1 OF EACH YEAR, EACH COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER A REPORT THAT SHOWS THE FINANCIAL CONDITION OF THE COMMUNITY HEALTH NETWORK ON THE LAST DAY OF THE PRECEDING CALENDAR YEAR AND ANY OTHER INFORMATION THAT THE COMMISSIONER REQUIRES BY REGULATION; AND

(2) ON OR BEFORE JUNE 1 OF EACH YEAR, EACH COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER AN AUDITED FINANCIAL REPORT FOR THE PRECEDING CALENDAR YEAR.

(B) (1) A COMMUNITY HEALTH NETWORK THAT HAS A FISCAL YEAR OTHER THAN THE CALENDAR YEAR MAY REQUEST PERMISSION TO FILE BOTH THE ANNUAL REPORT REQUIRED UNDER SUBSECTION (A)(1) OF THIS SECTION AND THE AUDITED FINANCIAL REPORT REQUIRED UNDER SUBSECTION (A)(2) OF THIS SECTION AT THE END OF ITS FISCAL YEAR RATHER THAN THE PRECEDING CALENDAR YEAR.

(2) IF THE COMMISSIONER GRANTS A REQUEST UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER:

(I) THE ANNUAL REPORT WITHIN 60 DAYS AFTER THE END OF ITS FISCAL YEAR; AND

(II) THE AUDITED FINANCIAL REPORT WITHIN 150 DAYS AFTER THE END OF ITS FISCAL YEAR.

(C) THE ANNUAL REPORT SHALL:

(1) BE ON THE FORMS THAT THE COMMISSIONER REQUIRES; AND

(2) INCLUDE A DESCRIPTION OF ANY CHANGES IN THE INFORMATION SUBMITTED UNDER § 19-1810 OF THIS SUBTITLE.

(D) THE AUDITED FINANCIAL REPORT SHALL:

(1) BE ON THE FORMS THAT THE COMMISSIONER REQUIRES; AND

(2) BE CERTIFIED BY AN AUDIT OF A CERTIFIED PUBLIC ACCOUNTING FIRM.

(E) EACH FINANCIAL REPORT FILED UNDER THIS SECTION IS A PUBLIC RECORD.

~~19-1815.~~ 19-1820.

(A) THE SECRETARY SHALL ADOPT REGULATIONS ON THE FOLLOWING:

(1) REQUIREMENTS FOR LICENSURE, INCLUDING A FEE FOR AN INITIAL APPLICATION AND AN ANNUAL FEE RENEWAL;

(2) QUALITY OF CARE STANDARDS;

(3) REQUIREMENTS REGARDING THE AVAILABILITY AND COMPREHENSIVENESS OF HEALTH CARE SERVICES; AND

(4) REQUIREMENTS REGARDING THE DEFINED POPULATION TO BE SERVED BY THE COMMUNITY HEALTH NETWORK.

(B) THE COMMISSIONER SHALL ADOPT REGULATIONS ON THE FOLLOWING:

(1) SETTING AN APPLICATION REVIEW FEE FOR THE REVIEW BY THE COMMISSIONER OF AN INITIAL APPLICATION AND AN ANNUAL RENEWAL REVIEW FEE;

(2) REQUIREMENTS FOR OPEN ENROLLMENT;

(3) PROVISIONS FOR INCENTIVES FOR COMMUNITY HEALTH NETWORKS TO ACCEPT AS ENROLLEES INDIVIDUALS WHO HAVE HIGH RISKS FOR NEEDING HEALTH CARE SERVICES AND INDIVIDUALS AND GROUPS WITH SPECIAL NEEDS;

(4) PROHIBITIONS AGAINST DISENROLLING INDIVIDUALS OR GROUPS WITH HIGH RISKS OR SPECIAL NEEDS;

~~(5) REQUIREMENTS THAT COMMUNITY HEALTH NETWORKS PROVIDE TO THEIR ENROLLEES INFORMATION ON COVERAGE, INCLUDING ANY LIMITATIONS ON COVERAGE, DEDUCTIBLES AND COPAYMENTS, OPTIONAL SERVICES AVAILABLE AND THE PRICE OR PRICES OF THOSE SERVICES; ANY RESTRICTIONS ON EMERGENCY SERVICES AND SERVICES PROVIDED OUTSIDE OF THE COMMUNITY HEALTH NETWORK'S SERVICE AREA, ANY RESPONSIBILITIES ENROLLEES HAVE, AND DESCRIBING HOW AN ENROLLEE CAN USE THE COMMUNITY HEALTH NETWORK'S ENROLLEE COMPLAINT RESOLUTION SYSTEM;~~

~~(6)~~ (5) SUBJECT TO § 19-1815 OF THIS SUBTITLE, REQUIREMENTS FOR FINANCIAL SOLVENCY AND STABILITY INCLUDING PROVISIONS THAT ALLOW FOR A

VARIETY OF OPTIONS FOR COMMUNITY HEALTH NETWORKS TO DEMONSTRATE THEIR ABILITY TO BEAR THE FINANCIAL RISK OF SERVING THEIR ENROLLEES AND THE PHASING IN OF SURPLUS AND RESERVE REQUIREMENTS AND OTHER REQUIREMENTS RELATING TO FINANCIAL SOLVENCY;

~~(7) FINANCIAL REPORTING AND EXAMINATION REQUIREMENTS;~~

~~(8)~~ (6) LIMITS ON COPAYMENTS AND DEDUCTIBLES;

~~(9)~~ (7) REQUIREMENTS FOR MAINTENANCE AND REPORTING OF INFORMATION ON COSTS, PRICES, REVENUES, VOLUME OF SERVICES, AND OUTCOMES AND QUALITY OF SERVICES;

~~(10)~~ (8) PROVISIONS FOR APPROPRIATE RISK ADJUSTERS OR OTHER METHODS TO PREVENT OR COMPENSATE FOR ADVERSE SELECTION OF ENROLLEES INTO OR OUT OF A COMMUNITY HEALTH NETWORK; AND

~~(11)~~ (9) SUBJECT TO § 19-1817 OF THIS SUBTITLE, PROVISIONS ESTABLISHING STANDARD MEASURES AND METHODS BY WHICH COMMUNITY HEALTH NETWORKS SHALL DETERMINE AND DISCLOSE THEIR PRICES, COPAYMENTS, DEDUCTIBLES, OUT-OF-POCKET LIMITS, ENROLLEE SATISFACTION LEVELS, AND ANTICIPATED LOSS RATIOS.

(C) THE SECRETARY AND THE COMMISSIONER SHALL JOINTLY ADOPT REGULATIONS ON PUBLIC UNDERSTANDING ISSUES.

~~19-1816.~~ 19-1821.

(A) IF THE SECRETARY OR THE COMMISSIONER DETERMINE THAT A COMMUNITY HEALTH NETWORK IS NOT OPERATING IN COMPLIANCE WITH THE PROVISIONS OF THIS SUBTITLE, THE SECRETARY OR COMMISSIONER SHALL NOTIFY THE DEPARTMENT OR THE ADMINISTRATION OF THAT DETERMINATION, REASONS FOR THE DETERMINATION, AND RECOMMEND METHODS OF CORRECTION, INCLUDING THE RESTRICTION, SUSPENSION, OR REVOCATION OF THE LICENSE OF THE COMMUNITY HEALTH NETWORK.

(B) AFTER NOTIFYING THE DEPARTMENT OR THE ADMINISTRATION, AS APPROPRIATE, UNDER SUBSECTION (A) OF THIS SECTION, THE SECRETARY AND THE COMMISSIONER SHALL MONITOR THE COMMUNITY HEALTH NETWORK ON A CONTINUOUS BASIS UNTIL THE SECRETARY AND THE COMMISSIONER DETERMINE THAT THE COMMUNITY HEALTH NETWORK IS OPERATING IN COMPLIANCE WITH THIS SUBTITLE.

(C) THE PROVISIONS OF ARTICLE 48A, SUBTITLE 10 OF THE CODE AND § 19-706.1 OF THE HEALTH - GENERAL ARTICLE REGARDING REHABILITATION AND LIQUIDATION APPLY TO COMMUNITY HEALTH NETWORKS TO THE SAME EXTENT THAT THESE PROVISIONS APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

~~19-1817.~~ 19-1822.

(A) THE SECRETARY AND THE COMMISSIONER SHALL ADOPT JOINT INTERNAL PROCEDURES TO ASSIST THEM IN WORKING TOGETHER AND WITH THE HEALTH RESOURCES PLANNING COMMISSION, THE HEALTH SERVICES COST REVIEW

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COMMISSION, AND THE HEALTH CARE ACCESS AND COST COMMISSION TO CARRY OUT THEIR RESPONSIBILITIES UNDER THIS SUBTITLE.

(B) THE JOINT INTERNAL PROCEDURES SHALL ESTABLISH MEANS BY WHICH THE DEPARTMENT AND THE COMMISSIONER MAY INFORM EACH OTHER PROMPTLY ON MATTERS THAT AFFECT ANY COMMUNITY HEALTH NETWORK, INCLUDING:

(1) ANY IMPORTANT ACTION, CHANGE, OR ARRANGEMENT THAT A COMMUNITY HEALTH NETWORK MAY UNDERTAKE; AND

(2) ANY REGULATORY PROBLEM.

~~19-1818.~~ 19-1823.

(A) A COMMUNITY HEALTH NETWORK MAY NOT:

(1) VIOLATE ANY PROVISION OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER IT;

(2) MAKE ANY FALSE STATEMENT WITH RESPECT TO ANY REPORT OR STATEMENT REQUIRED UNDER THIS SUBTITLE;

(3) PREVENT OR ATTEMPT TO PREVENT THE SECRETARY OR THE COMMISSIONER FROM PERFORMING ANY RESPONSIBILITY IMPOSED BY THIS SUBTITLE;

(4) FRAUDULENTLY OBTAIN OR ATTEMPT TO OBTAIN ANY BENEFIT UNDER THIS SUBTITLE; OR

(5) FAIL TO PROVIDE SERVICES TO AN ENROLLEE IN A TIMELY MANNER.

(B) IF A COMMUNITY HEALTH NETWORK VIOLATES THIS SECTION, THE SECRETARY OR THE COMMISSIONER MAY PURSUE ANY ONE OR MORE OF THE COURSES OF ACTION DESCRIBED IN ~~§ 19-1819~~ § 19-1824 OF THIS SUBTITLE.

~~19-1819.~~ 19-1824.

IF ANY PERSON VIOLATES ANY PROVISION OF THIS SUBTITLE, THE SECRETARY OR THE COMMISSIONER MAY:

(1) ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES A COMMUNITY HEALTH NETWORK TO:

(I) CEASE THE INAPPROPRIATE CONDUCT OR PRACTICES BY IT OR ANY OF THE PERSONNEL EMPLOYED OR ASSOCIATED WITH IT;

(II) FULFILL ITS CONTRACTUAL OBLIGATIONS;

(III) PROVIDE A SERVICE THAT HAS BEEN DENIED IMPROPERLY; OR

(IV) TAKE APPROPRIATE STEPS TO RESTORE ITS ABILITY TO PROVIDE A SERVICE THAT IS REQUIRED TO BE PROVIDED UNDER A CONTRACT;

(2) IMPOSE A PENALTY OF NOT MORE THAN $1,000 FOR EACH UNLAWFUL ACT COMMITTED;

(3) RESTRICT, SUSPEND, OR REVOKE THE LICENSE TO OPERATE AS A COMMUNITY HEALTH NETWORK; OR

(4) APPLY TO ANY COURT FOR LEGAL OR EQUITABLE RELIEF CONSIDERED APPROPRIATE BY THE SECRETARY.

~~19-1820.~~ 19-1825.

THIS SUBTITLE MAY BE CITED AS THE "COMMUNITY HEALTH NETWORK ACT".

Article - Health Occupations

14-501.

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

(2) (i) "Alternative health care system" means a system of health care delivery other than a hospital or related institution.

(ii) "Alternative health care system" includes:

1. A health maintenance organization;

2. A preferred provider organization;

3. A COMMUNITY HEALTH NETWORK, AS DEFINED IN § 19-1801 OF THE HEALTH - GENERAL ARTICLE;

[3.] 4. An independent practice association; or

[4.] 5. A community health center that is a nonprofit, freestanding ambulatory health care provider governed by a voluntary board of directors and that provides primary health care services to the medically indigent.

(3) "Medical review committee" means a committee or board that:

(i) Is within one of the categories described in subsection (b) of this section; and

(ii) Performs any of the functions listed in subsection (c) of this section.

(b) For purposes of this section, a medical review committee is:

(1) A regulatory board or agency established by State or federal law to license, certify, or discipline any provider of health care;

(2) A committee of the Faculty or any of its component societies or a committee of any other professional society or association composed of providers of health care;

(3) A committee appointed by or established in a local health department for review purposes;

(4) A committee appointed by or established in the Maryland Institute for Emergency Medical Services Systems;

(5) A committee of the medical staff or other committee, including any risk management, credentialing, or utilization review committee established in accordance with § 19-319 of the Health - General Article, of a hospital, related institution, or alternative health care system, if the governing board of the hospital,related institution, or alternative health care system forms and approves the committee or approves the written bylaws under which the committee operates;

(6) Any person, including a professional standard review organization, who contracts with an agency of this State or of the federal government to perform any of the functions listed in subsection (c) of this section;

(7) Any person who contracts with a provider of health care to perform any of those functions listed in subsection (c) of this section that are limited to the review of services provided by the provider of health care;

(8) An organization, established by the Maryland Hospital Association, Inc. and the Faculty, that contracts with a hospital, related institution, or alternative delivery system to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a hospital in meeting the requirements of § 19-319(e) of the Health - General Article; or

(9) A committee appointed by or established in an accredited health occupations school.

(c) For purposes of this section, a medical review committee:

(1) Evaluates and seeks to improve the quality of health care provided by providers of health care;

(2) Evaluates the need for and the level of performance of health care provided by providers of health care;

(3) Evaluates the qualifications, competence, and performance of providers of health care; or

(4) Evaluates and acts on matters that relate to the disciplineof any provider of health care.

(d) (1) Except as otherwise provided in this section, the proceedings, records, and files of a medical review committee are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee.

(2) The proceedings, records, and files of a medical review committee requested by the Department of Health and Mental Hygiene to ensure compliance with the provisions of § 19-319 of the Health - General Article are confidential and are not

discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1996.