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SB 519/96 - FIN CF 7lr1221

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**By: Delegates Hurson, Harrison, Love, and Krysiak**
Introduced and read first time: January 31, 1997
Assigned to: Economic Matters

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A BILL ENTITLED

1 AN ACT concerning

2 **Community Health Networks**

3 FOR the purpose of requiring community health networks to obtain a license from the
4 Secretary of Health and Mental Hygiene and the Insurance Commissioner prior to
5 contracting with certain persons or offering health care services to enrollees;
6 providing certain exceptions; providing for the purpose of this Act; specifying how
7 certain persons may form a community health network; specifying how a community
8 health network may operate under certain circumstances; specifying the
9 requirements of a community health network under this Act, including actuarial
10 soundness requirements, hold harmless provisions, marketing provisions, and rate
11 filing and contract provisions; specifying the duties and responsibilities of the
12 Secretary and Commissioner under this Act; requiring the Secretary and the
13 Commissioner to adopt certain regulations related to the regulation and operation
14 of community health networks; requiring the Secretary to adopt by regulation a
15 certain complaint system; requiring the Secretary and the Commissioner to adopt
16 certain joint internal procedures; establishing certain penalties; altering a provision
17 of law related to requirements of certain health insurers and other persons for
18 accepting and rejecting certain providers for participation on certain provider
19 panels to include a community health network; altering a certain provision of law
20 relating to medical review committees for the purpose of including a community
21 health network; altering a certain provision of law related to the referral of patients
22 to certain entities for the provision of certain health care services to include a
23 community health network; altering a certain provision of law to include a
24 community health network for purposes of determining whether a person is a third
25 party administrator; altering certain provisions of law to include a community health
26 network for purposes of providing health insurance benefits in the small group
27 market; providing for the application of this Act; defining certain terms; and
28 generally relating to the operation and regulation of community health networks.

29 BY repealing and reenacting, with amendments,
30 Article - Insurance
31 Section 8-301(b)
32 Annotated Code of Maryland
33 (1995 Volume and 1996 Supplement)
34 (As enacted by Chapter 36 of the Acts of the General Assembly of 1995)

1 BY repealing and reenacting, without amendments,
2 Article - Insurance
3 Section 15-112(a)(1) and (b) and 15-1201(a)
4 Annotated Code of Maryland
5 (1995 Volume and 1996 Supplement)
6 (As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of
7 1997)

8 BY repealing and reenacting, with amendments,
9 Article - Insurance
10 Section 15-112(a)(2), 15-116(a), and 15-1201(c) and (f)(1)
11 Annotated Code of Maryland
12 (1995 Volume and 1996 Supplement)
13 (As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of
14 1997)

15 BY adding to
16 Article - Health - General
17 Section 19-2001 through 19-2026, inclusive, to be under the new subtitle "Subtitle
18 20. Community Health Networks"
19 Annotated Code of Maryland
20 (1994 Replacement Volume and 1996 Supplement)

21 BY repealing and reenacting, without amendments,
22 Article - Health Occupations
23 Section 14-501(a)(1) and (3), (b), (c), and (d)
24 Annotated Code of Maryland
25 (1994 Replacement Volume and 1996 Supplement)

26 BY repealing and reenacting, with amendments,
27 Article - Health Occupations
28 Section 1-302(d) and 14-501(a)(2)
29 Annotated Code of Maryland
30 (1994 Replacement Volume and 1996 Supplement)

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

33 **Article - Insurance**

34 8-301.

35 (b) (1) "Administrator" means a person that, to the extent that the person
36 acting for an insurer or plan sponsor, has:

37 (i) control over or custody of premiums, contributions, or any other
38 money with respect to a plan, for any period of time; or

1 (ii) discretionary authority over the adjustment, payment, or
2 settlement of benefit claims under a plan or over the investment of a plan's assets.

3 (2) "Administrator" does not include a person that:

4 (i) with respect to a particular plan:

5 1. is, or is an employee of, the plan sponsor;

6 2. is, or is an employee, agent, or managing general agent of, an
7 insurer [or], health maintenance organization, OR COMMUNITY HEALTH NETWORK
8 that insures or administers the plan; or

9 3. is a broker that solicits, procures, or negotiates a plan for a
10 plan sponsor and that has no authority over the adjustment, payment, or settlement of
11 benefit claims under the plan or over the investment or handling of the plan's assets;

12 (ii) is retained by the Life and Health Insurance Guaranty
13 Corporation to administer a plan underwritten by an impaired insurer that is subject to an
14 order of conservation, liquidation, or rehabilitation;

15 (iii) is a participant or beneficiary of a plan that provides for individual
16 accounts and allows a participant or beneficiary to exercise investment control over assets
17 in the participant's or beneficiary's account, and the participant or beneficiary exercises
18 that investment control;

19 (iv) administers only plans that are subject to ERISA and that do not
20 provide benefits through insurance, unless any of the plans administered is a multiple
21 employer welfare arrangement as defined in § 514(b)(6)(A)(ii) of ERISA;

22 (v) is, or is an employee of, a bank, savings bank, trust company,
23 savings and loan association, or credit union that is regulated under the laws of this State,
24 another state, or the United States; or

25 (vi) is, or is an employee of, a person that is registered as:

26 1. an investment adviser under the Investment Advisers Act of
27 1940 or the Maryland Securities Act;

28 2. a broker-dealer or transfer agent under the Securities
29 Exchange Act of 1934 or the Maryland Securities Act; or

30 3. an investment company under the Investment Company Act
31 of 1940.

32 15-112.

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

34 (2) (i) "Carrier" means:

35 1. an insurer;

36 2. a nonprofit health service plan;

1 3. a health maintenance organization;

2 4. a dental plan organization; [or]

3 5. A COMMUNITY HEALTH NETWORK, AS DEFINED UNDER §
4 19-2001 OF THE HEALTH - GENERAL ARTICLE; OR

5 [5.] 6. any other person that provides health benefit plans
6 subject to regulation by the State.

7 (ii) "Carrier" includes an entity that arranges a provider panel for a
8 carrier.

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

10 (1) review applications for participation on the carrier's provider panel in
11 accordance with this section;

12 (2) notify an enrollee of:

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

15 (ii) the right of the enrollee, on request, to continue to receive health
16 care services from the enrollee's primary care provider for up to 90 days after the date of
17 the notice of termination of the enrollee's primary care provider from the carrier's
18 provider panel, if the termination was for reasons unrelated to fraud, patient abuse,
19 incompetency, or loss of licensure status;

20 (3) notify primary care providers on the carrier's provider panel of the
21 termination of a specialty referral services provider; and

22 (4) notify a provider at least 90 days before the date of the termination of
23 the provider from the carrier's provider panel, if the termination is for reasons unrelated
24 to fraud, patient abuse, incompetency, or loss of licensure status.

25 15-116.

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

27 (2) "Carrier" means:

28 (i) an insurer;

29 (ii) a nonprofit health service plan;

30 (iii) a health maintenance organization;

31 (iv) a dental plan organization; [or]

32 (V) A COMMUNITY HEALTH NETWORK, AS DEFINED UNDER §
33 19-2001 OF THE HEALTH - GENERAL ARTICLE; OR

34 [(v)] (VI) any other person that provides health benefit plans subject to
35 regulation by the State.

1 (3) "Health care provider" means an individual who is licensed, certified, or
2 otherwise authorized under the Health Occupations Article to provide health care
3 services.

4 15-1201.

5 (a) In this subtitle the following words have the meanings indicated.

6 (c) "Carrier" means a person that:

7 (1) offers health benefit plans in the State covering eligible employees of
8 small employers; and

9 (2) is:

10 (i) an authorized insurer that provides health insurance in the State;

11 (ii) a nonprofit health service plan that is licensed to operate in the
12 State;

13 (iii) a health maintenance organization that is licensed to operate in
14 the State; [or]

15 (IV) A COMMUNITY HEALTH NETWORK THAT IS LICENSED TO
16 OPERATE IN THE STATE; OR

17 [(iv)] (V) any other person or organization that provides health benefit
18 plans subject to State insurance regulation.

19 (f) (1) "Health benefit plan" means:

20 (i) a policy or certificate for hospital or medical benefits;

21 (ii) a nonprofit health service plan; [or]

22 (iii) a health maintenance organization subscriber or group master
23 contract; OR

24 (IV) A COMMUNITY HEALTH NETWORK.

25 **Article - Health - General**

26 SUBTITLE 20. COMMUNITY HEALTH NETWORKS.

27 19-2001. DEFINITIONS.

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

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

32 (C) "AFFILIATED PROVIDERS OR AFFILIATED GROUPS OF PROVIDERS"
33 MEANS THOSE HEALTH CARE PROVIDERS THAT:

1 (1) ARE UNDER THE COMMON CONTROL AND OWNERSHIP OF A
2 COMMUNITY HEALTH NETWORK; OR

3 (2) HAVE ENTERED INTO CONTRACTUAL RELATIONSHIPS WITHIN A
4 COMMUNITY HEALTH NETWORK WHERE THE HEALTH CARE PROVIDERS SHARE
5 SUBSTANTIAL FINANCIAL RISK.

6 (D) "COMMISSIONER" MEANS THE STATE INSURANCE COMMISSIONER.

7 (E) "COMMUNITY HEALTH NETWORK" MEANS AN ENTITY THAT:

8 (1) IS A LEGAL AGGREGATION OF HEALTH CARE PROVIDERS
9 OPERATING COLLECTIVELY FOR THE PURPOSE OF PROVIDING HEALTH CARE
10 SERVICES TO A DEFINED POPULATION ON A PREPAID OR FIXED PAYMENT PER TIME
11 PERIOD BASIS;

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

16 (3) PROVIDES AT LEAST 65% OF THE HEALTH CARE SERVICES
17 REQUIRED UNDER CONTRACT WITH A PURCHASER DIRECTLY THROUGH A HEALTH
18 CARE PROVIDER, AFFILIATED PROVIDERS, OR AFFILIATED GROUPS OF PROVIDERS;
19 AND

20 (4) PROVIDES OR ARRANGES FOR THE PROVISION OF:

21 (I) A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES AS
22 REQUIRED UNDER:

23 1. TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE WHEN
24 OPERATING IN THE SMALL GROUP MARKET;

25 2. TITLE 19, SUBTITLE 7 OF THIS ARTICLE FOR HEALTH
26 MAINTENANCE ORGANIZATIONS WHEN OPERATING IN THE COMMERCIAL MARKET;
27 OR

28 3. THE FEDERAL MEDICARE PROGRAM WHEN OPERATING
29 UNDER A RISK CONTRACT WITH THE MEDICARE PROGRAM; OR

30 (II) A LIMITED SET OF INTEGRATED HEALTH CARE SERVICES FOR
31 INDIVIDUALS ENROLLED IN A GOVERNMENTAL PROGRAM TO PROVIDE HEALTH
32 CARE SERVICES TO LOW INCOME INDIVIDUALS WHO ARE UNINSURED OR
33 UNDERINSURED.

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

37 (G) "HEALTH CARE PROVIDER" MEANS:

38 (1) AN INDIVIDUAL WHO IS LICENSED, CERTIFIED, OR OTHERWISE
39 AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH

1 CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A
2 PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM;

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

6 (3) A FEDERALLY OR STATE QUALIFIED COMMUNITY HEALTH CENTER.

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

9 (2) "HEALTH CARE SERVICES" INCLUDES:

10 (I) AMBULANCE SERVICES;

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

12 (III) AUDIOLOGIC CARE AND SERVICES;

13 (IV) CHIROPRACTIC CARE AND SERVICES;

14 (V) CONVALESCENT INSTITUTIONAL CARE;

15 (VI) DENTAL CARE AND SERVICES;

16 (VII) EXTENDED CARE;

17 (VIII) FAMILY PLANNING OR INFERTILITY SERVICES;

18 (IX) HEALTH EDUCATION SERVICES;

19 (X) HOME HEALTH CARE OR MEDICAL SOCIAL SERVICES;

20 (XI) HOSPICE SERVICES;

21 (XII) INPATIENT HOSPITAL SERVICES;

22 (XIII) LABORATORY, RADIOLOGICAL, OR OTHER DIAGNOSTIC
23 SERVICES;

24 (XIV) MARRIAGE AND FAMILY THERAPY;

25 (XV) MEDICAL CARE AND SERVICES;

26 (XVI) MEDICAL NUTRITION THERAPY;

27 (XVII) MENTAL HEALTH SERVICES;

28 (XVIII) NURSING CARE AND SERVICES;

29 (XIX) NURSING HOME CARE;

30 (XX) OPTICAL CARE AND SERVICES;

31 (XXI) OPTOMETRIC CARE AND SERVICES;

32 (XXII) OSTEOPATHIC CARE AND SERVICES;

1 (XXIII) OUTPATIENT SERVICES;

2 (XXIV) PHARMACEUTICAL SERVICES;

3 (XXV) PHYSICAL THERAPY CARE AND SERVICES;

4 (XXVI) PODIATRIC CARE AND SERVICES;

5 (XXVII) PREVENTIVE MEDICAL SERVICES;

6 (XXVIII) PSYCHOLOGICAL CARE AND SERVICES;

7 (XXIX) REHABILITATIVE SERVICES;

8 (XXX) SPEECH PATHOLOGY SERVICES;

9 (XXXI) SURGICAL CARE AND SERVICES;

10 (XXXII) TREATMENT FOR ALCOHOLISM OR DRUG ABUSE; AND

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

14 (I) "PAYOR" MEANS:

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

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

21 (J) (1) "PURCHASER" MEANS ANY PERSON WITH WHICH A COMMUNITY
22 HEALTH NETWORK DIRECTLY CONTRACTS TO PROVIDE HEALTH CARE SERVICES
23 ON A PREPAID OR FIXED PAYMENT PER TIME PERIOD BASIS TO A DEFINED
24 POPULATION.

25 (2) "PURCHASER" INCLUDES:

26 (I) AN INDIVIDUAL;

27 (II) AN EMPLOYER; OR

28 (III) A GOVERNMENTAL ENTITY.

29 19-2002. PURPOSE.

30 THE PURPOSE OF THIS SUBTITLE IS TO:

31 (1) FOSTER THE DEVELOPMENT OF COMMUNITY HEALTH NETWORKS
32 THAT WILL BE RESPONSIBLE FOR ARRANGING FOR OR DELIVERING TO A DEFINED
33 POPULATION ON AN INSURED, PREPAID, OR FIXED PRICE BASIS A CONTINUUM OF
34 INTEGRATED HEALTH CARE SERVICES;

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

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

7 (4) PROVIDE ONE OVERALL STATE LAW THAT:

8 (I) REGULATES COMMUNITY HEALTH NETWORKS;

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

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

13 (5) PROVIDE FOR THE REGULATION:

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

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

20 19-2003. SCOPE OF SUBTITLE.

21 THIS SUBTITLE DOES NOT APPLY TO A NETWORK OF HEALTH CARE PROVIDERS
22 THAT:

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

25 (2) IS CONTRACTING DIRECTLY UNDER A CAPITATED OR OTHER
26 RISK-SHARING ARRANGEMENT WITH A PAYOR OR A GOVERNMENTAL ENTITY
27 WHERE THE PAYOR OR THE GOVERNMENTAL ENTITY IS RESPONSIBLE FOR THE
28 FINANCIAL RISK OF PROVIDING HEALTH CARE SERVICES TO ENROLLEES.

29 19-2004. LICENSURE REQUIREMENT.

30 (A) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE, A COMMUNITY
31 HEALTH NETWORK SHALL BE LICENSED JOINTLY BY THE SECRETARY AND THE
32 COMMISSIONER TO OPERATE AS A COMMUNITY HEALTH NETWORK BEFORE IT MAY
33 ENTER INTO ANY CONTRACT WITH A PURCHASER TO PROVIDE HEALTH CARE
34 SERVICES TO A DEFINED POPULATION ON A PREPAID OR FIXED PAYMENT PER TIME
35 PERIOD BASIS.

36 (B) THE DEPARTMENT SHALL BE THE POINT OF ENTRY FOR A COMMUNITY
37 HEALTH NETWORK SEEKING TO OBTAIN A LICENSE TO OPERATE IN THE STATE AND
38 FOR ENROLLEES AND OTHER PERSONS TO MAKE COMPLAINTS CONCERNING THE
39 OPERATION OF A COMMUNITY HEALTH NETWORK.

1 (C) (1) THE SECRETARY AND THE COMMISSIONER SHALL ISSUE A LICENSE
2 TO AN APPLICANT THAT MEETS THE REQUIREMENTS OF THIS SUBTITLE AND ALL
3 APPLICABLE REGULATIONS ADOPTED BY THE SECRETARY OR THE COMMISSIONER
4 UNDER THIS SUBTITLE.

5 (2) A LICENSE MAY NOT BE ISSUED UNLESS BOTH THE SECRETARY AND
6 THE COMMISSIONER CERTIFY THAT THE REQUIREMENTS OF THIS SUBTITLE HAVE
7 BEEN MET.

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

9 19-2005. ADOPTION OF JOINT INTERNAL PROCEDURES.

10 (A) THE SECRETARY AND THE COMMISSIONER SHALL ADOPT JOINT
11 INTERNAL PROCEDURES TO ASSIST THEM IN WORKING TOGETHER AND WITH THE
12 HEALTH RESOURCES PLANNING COMMISSION, THE HEALTH SERVICES COST REVIEW
13 COMMISSION, AND THE HEALTH CARE ACCESS AND COST COMMISSION TO CARRY
14 OUT THEIR RESPONSIBILITIES UNDER THIS SUBTITLE.

15 (B) THE JOINT INTERNAL PROCEDURES SHALL:

16 (1) ESTABLISH A MEANS BY WHICH THE DEPARTMENT AND THE
17 COMMISSIONER MAY INFORM EACH OTHER PROMPTLY ON MATTERS THAT AFFECT
18 ANY COMMUNITY HEALTH NETWORK, INCLUDING:

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

21 (II) ANY REGULATORY MATTER; AND

22 (2) ESTABLISH MEANS TO COORDINATE AND INTEGRATE THE
23 REGULATION OF THE INDIVIDUAL HEALTH CARE PROVIDER COMPONENTS OF
24 COMMUNITY HEALTH NETWORKS.

25 19-2006. RESPONSIBILITIES OF DEPARTMENT AND COMMISSIONER.

26 (A) THE SECRETARY SHALL:

27 (1) BE RESPONSIBLE FOR DETERMINING WHETHER EACH COMMUNITY
28 HEALTH NETWORK IS OR WILL BE ABLE TO COMPLY WITH THE REQUIREMENTS OF
29 THIS SUBTITLE AND REGULATIONS ADOPTED UNDER THIS SUBTITLE REGARDING
30 QUALITY OF CARE AND PUBLIC ACCOUNTABILITY ISSUES; AND

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

34 (B) (1) THE SECRETARY SHALL ESTABLISH BY REGULATION A COMPLAINT
35 SYSTEM FOR THE RECEIPT AND TIMELY INVESTIGATION OF COMPLAINTS.

36 (2) THE COMPLAINT SYSTEM SHALL INCLUDE:

37 (I) A PROCEDURE FOR THE TIMELY ACKNOWLEDGMENT OF THE
38 RECEIPT OF A COMPLAINT, INCLUDING ENROLLEE COMPLAINTS; AND

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

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

9 (C) THE COMMISSIONER IS RESPONSIBLE FOR:

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

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

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

19 19-2007. REGULATIONS.

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

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

23 (2) QUALITY OF CARE STANDARDS;

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

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

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

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

32 (2) REQUIREMENTS FOR OPEN ENROLLMENT;

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

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

1 (5) SUBJECT TO § 19-2012 OF THIS SUBTITLE, REQUIREMENTS FOR
2 FINANCIAL SOLVENCY AND STABILITY;

3 (6) LIMITS ON COPAYMENTS AND DEDUCTIBLES;

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

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

10 (9) PROVISIONS ESTABLISHING STANDARD MEASURES AND METHODS
11 BY WHICH COMMUNITY HEALTH NETWORKS SHALL DETERMINE AND DISCLOSE
12 THEIR PRICES, COPAYMENTS, DEDUCTIBLES, OUT-OF-POCKET LIMITS, ENROLLEE
13 SATISFACTION LEVELS, AND ANTICIPATED LOSS RATIOS.

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

16 19-2008. BASIC REQUIREMENTS TO OPERATE AS A COMMUNITY HEALTH NETWORK.

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

19 (1) HEALTH CARE PROVIDERS;

20 (2) INSURERS;

21 (3) NONPROFIT HEALTH SERVICE PLANS;

22 (4) HEALTH MAINTENANCE ORGANIZATIONS;

23 (5) EMPLOYERS; OR

24 (6) ANY OTHER BUSINESS OR LEGAL ENTITIES.

25 (B) A COMMUNITY HEALTH NETWORK SHALL:

26 (1) PROVIDE AT LEAST 65% OF THE HEALTH CARE SERVICES REQUIRED
27 UNDER A CONTRACT WITH A PURCHASER IN ACCORDANCE WITH THE PROVISIONS
28 OF THIS SUBTITLE DIRECTLY THROUGH A HEALTH CARE PROVIDER, AFFILIATED
29 PROVIDERS, OR AFFILIATED GROUPS OF PROVIDERS; AND

30 (2) PROVIDE OR ARRANGE FOR THE PROVISION OF:

31 (I) A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES AS
32 REQUIRED UNDER:

33 1. TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE WHEN
34 OPERATING IN THE SMALL GROUP MARKET;

1 2. TITLE 19, SUBTITLE 7 OF THIS ARTICLE FOR HEALTH
2 MAINTENANCE ORGANIZATIONS WHEN OPERATING IN THE COMMERCIAL MARKET;
3 OR

4 3. THE FEDERAL MEDICARE PROGRAM WHEN OPERATING
5 UNDER A RISK CONTRACT WITH THE MEDICARE PROGRAM; OR

6 (II) A LIMITED SET OF INTEGRATED HEALTH CARE SERVICES FOR
7 INDIVIDUALS ENROLLED IN A GOVERNMENTAL PROGRAM TO PROVIDE HEALTH
8 CARE SERVICES TO LOW INCOME INDIVIDUALS.

9 (C) (1) A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE
10 IS NOT ENTITLED TO AN EXEMPTION FROM OTHER PROVISIONS OF LAW RELATING
11 TO:

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

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

16 (2) PARAGRAPH (1) OF THIS SUBSECTION DOES NOT PROHIBIT A
17 COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE THAT INCLUDES
18 A HOSPITAL FROM NEGOTIATING A CAPITATION ARRANGEMENT OR PREMIUM FOR
19 THE ENTIRE COMMUNITY HEALTH NETWORK IF THE HOSPITAL CAPITATION
20 ARRANGEMENT HAS BEEN REVIEWED AND APPROVED BY THE HEALTH SERVICES
21 COST REVIEW COMMISSION.

22 (D) A COMMUNITY HEALTH NETWORK MAY OPERATE AS AUTHORIZED
23 UNDER THIS SUBTITLE NOTWITHSTANDING ANY PROHIBITION AGAINST THE
24 CORPORATE PRACTICE OF MEDICINE.

25 19-2009. PUBLIC ACCOUNTABILITY.

26 (A) (1) EACH COMMUNITY HEALTH NETWORK SHALL ESTABLISH A
27 WRITTEN QUALITY IMPROVEMENT PLAN TO ASSURE THE CONTINUING DELIVERY
28 OF QUALITY HEALTH CARE SERVICES TO ENROLLEES.

29 (2) THE QUALITY IMPROVEMENT PLAN SHALL:

30 (I) IDENTIFY THE COMMUNITY HEALTH NETWORK'S HEALTH
31 CARE PRIORITIES AND OBJECTIVES, INCLUDING A DESCRIPTION OF HOW THESE
32 PRIORITIES AND OBJECTIVES RELATING TO THE HEALTH STATUS PROBLEMS AND
33 NEEDS OF ITS ENROLLEES WILL BE PROVIDED FOR;

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

38 (III) ESTABLISH PROCEDURES FOR WORKING WITH OTHER
39 EXISTING HEALTH BENEFIT PLANS, LOCAL HEALTH DEPARTMENTS, HEALTH CARE
40 PROVIDERS THAT HAVE HISTORICALLY PROVIDED HEALTH CARE SERVICES WITHIN

1 THE COMMUNITY, AND COMMUNITY ORGANIZATIONS SERVING THE SAME
2 COMMUNITY TO DEVELOP AND IMPLEMENT A PROCESS FOR IMPROVING THE
3 HEALTH STATUS OF THE COMMUNITY; AND

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

8 (3) (I) UNLESS THE COMMUNITY HEALTH NETWORK RECEIVES A
9 WAIVER FROM THE DEPARTMENT, THE DEPARTMENT SHALL REVIEW AND APPROVE
10 THE QUALITY IMPROVEMENT PLAN OF EACH COMMUNITY HEALTH NETWORK
11 EVERY 2 YEARS.

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

15 (B) EACH COMMUNITY HEALTH NETWORK SHALL:

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

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

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

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

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

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

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

33 (II) HEALTH PRIORITIES AND OBJECTIVES IN THE COMMUNITY.

34 19-2010.

35 A COMMUNITY HEALTH NETWORK SHALL BE GOVERNED BY A BOARD OF
36 DIRECTORS THAT:

37 (1) IS COMPRISED OF A MAJORITY OF MEMBERS WHO ARE MARYLAND
38 RESIDENTS; AND

1 (2) INCLUDES SIGNIFICANT PARTICIPATION AND REPRESENTATION BY
2 LOCAL PHYSICIANS AND OTHER HEALTH CARE PROVIDERS.

3 19-2011. DATA REPORTING.

4 EACH COMMUNITY HEALTH NETWORK SHALL:

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

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

12 (3) REPORT INFORMATION CONSISTENT WITH THE REQUIREMENTS OF
13 THE MARYLAND MEDICAL CARE DATABASE ESTABLISHED UNDER § 19-1507 OF THIS
14 TITLE; AND

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

20 19-2012. FINANCIAL SOLVENCY REQUIREMENTS.

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

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

24 (B) (1) A COMMUNITY HEALTH NETWORK SHALL HAVE AN INITIAL
25 SURPLUS THAT EXCEEDS ITS LIABILITIES BY AT LEAST $1,500,000.

26 (2) (I) ALL COMMUNITY HEALTH NETWORKS SHALL MAINTAIN A
27 SURPLUS THAT EXCEEDS ITS LIABILITIES IN THE AMOUNT THAT IS AT LEAST EQUAL
28 TO THE GREATER OF $750,000 OR 5% OF THE SUBSCRIPTION CHARGES EARNED
29 DURING THE PRIOR CALENDAR YEAR AS RECORDED IN ITS ANNUAL REPORT FILED
30 WITH THE COMMISSIONER.

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

33 (C) (1) FOR THE PROTECTION OF THE COMMUNITY HEALTH NETWORK'S
34 ENROLLEES AND CREDITORS, A COMMUNITY HEALTH NETWORK APPLYING FOR A
35 LICENSE TO OPERATE AS A COMMUNITY HEALTH NETWORK UNDER THIS SUBTITLE
36 SHALL DEPOSIT AND MAINTAIN IN TRUST WITH THE STATE TREASURER $100,000 IN
37 CASH OR GOVERNMENT SECURITIES OF THE TYPE DESCRIBED IN § 5-701(B) OF THE
38 INSURANCE ARTICLE.

1 (2) (I) THE DEPOSITS SHALL BE ACCEPTED AND HELD IN TRUST BY
2 THE STATE TREASURER IN ACCORDANCE WITH THE PROVISIONS OF §§ 5-701
3 THROUGH 5-709 OF THE INSURANCE ARTICLE.

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

6 (D) THE COMMISSIONER MAY WAIVE THE SURPLUS AND DEPOSIT
7 REQUIREMENTS CONTAINED IN THIS SECTION IF THE COMMISSIONER IS SATISFIED
8 THAT:

9 (1) THE COMMUNITY HEALTH NETWORK HAS SUFFICIENT NET WORTH
10 AND AN ADEQUATE HISTORY OF GENERATING NET INCOME TO ASSURE FINANCIAL
11 VIABILITY FOR THE NEXT YEAR;

12 (2) THE COMMUNITY HEALTH NETWORK'S PERFORMANCE AND
13 OBLIGATIONS ARE GUARANTEED BY ANOTHER PERSON WITH SUFFICIENT NET
14 WORTH AND AN ADEQUATE HISTORY OF GENERATING NET INCOME; OR

15 (3) THE ASSETS OF THE COMMUNITY HEALTH NETWORK OR
16 CONTRACTS WITH INSURERS, GOVERNMENTAL ENTITIES, PROVIDERS, OR OTHER
17 PERSONS ARE SUFFICIENT TO REASONABLY ASSURE THE PERFORMANCE OF THE
18 COMMUNITY HEALTH NETWORK'S OBLIGATIONS.

19 (E) (1) THE PROCEDURES FOR OFFERING HEALTH CARE SERVICES AND
20 OFFERING AND TERMINATING CONTRACTS TO ENROLLEES MAY NOT DISCRIMINATE
21 UNFAIRLY ON THE BASIS OF AGE, SEX, RACE, HEALTH, OR ECONOMIC STATUS.

22 (2) PARAGRAPH (1) OF THIS SUBSECTION DOES NOT PROHIBIT:

23 (I) REASONABLE UNDERWRITING CLASSIFICATIONS FOR
24 ESTABLISHING CONTRACT RATES; OR

25 (II) EXPERIENCE RATING.

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

29 (2) THE HOLD HARMLESS CLAUSE SHALL PROVIDE THAT THE HEALTH
30 CARE PROVIDER MAY NOT, UNDER ANY CIRCUMSTANCES, INCLUDING
31 NONPAYMENT OF MONEYS DUE THE PROVIDERS BY THE COMMUNITY HEALTH
32 NETWORK, INSOLVENCY OF THE COMMUNITY HEALTH NETWORK, OR BREACH OF
33 THE PROVIDER CONTRACT, BILL, CHARGE, COLLECT A DEPOSIT, SEEK
34 COMPENSATION, REMUNERATION, OR REIMBURSEMENT FROM, OR HAVE ANY
35 RECOURSE AGAINST THE ENROLLEE, PATIENT, OR ANY PERSONS OTHER THAN THE
36 COMMUNITY HEALTH NETWORK ACTING ON THEIR BEHALF, FOR HEALTH CARE
37 SERVICES PROVIDED IN ACCORDANCE WITH THE PROVIDER CONTRACT.

38 (3) COLLECTION FROM THE ENROLLEE OF COPAYMENTS OR
39 SUPPLEMENTAL CHARGES IN ACCORDANCE WITH THE TERMS OF THE ENROLLEE'S
40 CONTRACT WITH THE COMMUNITY HEALTH NETWORK, OR CHARGES FOR HEALTH

1 CARE SERVICES NOT COVERED UNDER THE ENROLLEE'S CONTRACT, MAY BE
2 EXCLUDED FROM THE HOLD HARMLESS CLAUSE.

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

6 (G) A COMMUNITY HEALTH NETWORK SHALL PROVIDE EVIDENCE OF
7 ADEQUATE INSURANCE COVERAGE OR AN ADEQUATE PLAN FOR SELF-INSURANCE
8 TO SATISFY CLAIMS FOR INJURIES THAT MAY OCCUR FROM PROVIDING HEALTH
9 CARE SERVICES.

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

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

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

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

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

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

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

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

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

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

1 2. 365 DAYS.

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

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

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

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

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

12 (III) RESERVES;

13 (IV) LETTERS OF CREDIT;

14 (V) GUARANTEES; OR

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

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

23 19-2013. OPEN ENROLLMENT.

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

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

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

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

37 (4) WHERE AND IN WHAT MANNER AN ENROLLEE MAY OBTAIN
38 HEALTH CARE SERVICES, INCLUDING PROCEDURES FOR SELECTING OR CHANGING

1 PRIMARY CARE PHYSICIANS AND THE LOCATIONS OF HOSPITALS AND OUTPATIENT
2 TREATMENT CENTERS THAT ARE UNDER CONTRACT WITH THE COMMUNITY
3 HEALTH NETWORK TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES;

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

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

9 19-2014. ENROLLEE COMPLAINT SYSTEM.

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

12 (B) THE COMPLAINT SYSTEM SHALL INCLUDE:

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

16 (2) A DISCLOSURE THAT IF A COMPLAINT IS NOT SATISFIED TO THE
17 SATISFACTION OF THE ENROLLEE, THE ENROLLEE MAY CONTACT THE
18 DEPARTMENT IN ACCORDANCE WITH § 19-2006 OF THIS SUBTITLE.

19 19-2015. LICENSE APPLICATION REQUIREMENTS.

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

22 (1) SUBMIT AN APPLICATION TO THE SECRETARY;

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

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

27 (B) THE APPLICATION SHALL:

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

31 (2) BE SIGNED AND VERIFIED BY THE APPLICANT.

32 (C) THE APPLICATION SHALL BE ACCOMPANIED BY:

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

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

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

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

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

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

15 (I) THE ADMINISTRATOR;

16 (II) THE MEDICAL DIRECTOR;

17 (III) THE ENROLLMENT DIRECTOR; AND

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

21 (7) A STATEMENT THAT DESCRIBES GENERALLY:

22 (I) THE COMMUNITY HEALTH NETWORK, INCLUDING:

23 1. ITS OPERATIONS;

24 2. ITS ENROLLMENT PROCESS;

25 3. ITS QUALITY ASSURANCE MECHANISM; AND

26 4. ITS INTERNAL GRIEVANCE PROCEDURES;

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

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

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

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

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

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

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

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

11 (I) SOURCES OF FINANCIAL SUPPORT;

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

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

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

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

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

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

28 19-2016. LICENSE RENEWAL REQUIREMENTS.

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

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

34 (1) OTHERWISE IS ENTITLED TO BE LICENSED;

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

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

1 (4) SUBMITS TO THE SECRETARY:

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

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

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

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

13 19-2017. DENIAL OF LICENSE OR REFUSAL TO RENEW LICENSE.

14 (A) THE SECRETARY AND THE COMMISSIONER MAY DENY A LICENSE TO ANY
15 APPLICANT OR SUSPEND, RESTRICT, OR REVOKE A LICENSE IF THE APPLICANT OR
16 LICENSEE DOES NOT MEET THE REQUIREMENTS OF THIS SUBTITLE OR ANY
17 REGULATIONS THAT ARE ADOPTED UNDER THIS SUBTITLE.

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

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

24 19-2018. RATES AND CONTRACTS.

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

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

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

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

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

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

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

6 19-2019. MARKETING DOCUMENTS.

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

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

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

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

15 (4) EACH DEDUCTIBLE FEATURE;

16 (5) EACH COPAYMENT PROVISION; AND

17 (6) ALL INFORMATION REQUIRED BY § 15-1206(B) OF THE INSURANCE
18 ARTICLE.

19 19-2020. FINANCIAL AFFAIRS.

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

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

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

27 (II) GIVE THEM CONVENIENT ACCESS TO ALL BOOKS, RECORDS,
28 PAPERS, AND DOCUMENTS THAT RELATE TO THE BUSINESS OF THE COMMUNITY
29 HEALTH NETWORK, INCLUDING FINANCIAL RECORDS OF HEALTH CARE PROVIDERS
30 THAT PROVIDE HEALTH CARE SERVICES UNDER CONTRACT.

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

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

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

5 19-2021. ANNUAL REPORTS.

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

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

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

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

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

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

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

30 (C) THE ANNUAL REPORT SHALL:

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

32 (2) INCLUDE A DESCRIPTION OF ANY CHANGES IN THE INFORMATION
33 SUBMITTED UNDER § 19-2015 OF THIS SUBTITLE.

34 (D) THE AUDITED FINANCIAL REPORT SHALL:

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

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

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

1 19-2022. SUPERVISION OF COMMUNITY HEALTH NETWORKS.

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

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

15 (C) THE PROVISIONS OF TITLE 9, SUBTITLE 2 OF THE INSURANCE ARTICLE
16 AND § 19-706.1 OF THIS TITLE REGARDING REHABILITATION AND LIQUIDATION
17 APPLY TO COMMUNITY HEALTH NETWORKS TO THE SAME EXTENT THAT THESE
18 PROVISIONS APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

19 19-2023. APPLICABILITY OF TAX LAWS.

20 A COMMUNITY HEALTH NETWORK LICENSED UNDER THE PROVISIONS OF THIS
21 TITLE SHALL BE EXEMPT FROM PAYING THE PREMIUM TAX IMPOSED UNDER
22 ARTICLE 48A, § 632 OF THE CODE.

23 19-2024. PROHIBITED ACTS.

24 (A) A COMMUNITY HEALTH NETWORK MAY NOT:

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

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

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

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

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

36 (B) IF A COMMUNITY HEALTH NETWORK VIOLATES THIS SECTION, THE
37 SECRETARY OR THE COMMISSIONER MAY PURSUE ANY ONE OR MORE OF THE
38 COURSES OF ACTION DESCRIBED IN § 19-2025 OF THIS SUBTITLE.

1 19-2025. PENALTIES.

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

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

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

8 (II) FULFILL ITS CONTRACTUAL OBLIGATIONS;

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

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

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

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

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

19 19-2026. SHORT TITLE.

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

21 **Article - Health Occupations**

22 1-302.

23 (d) The provisions of this section do not apply to:

24 (1) A health care practitioner when treating a member of a health
25 maintenance organization as defined in § 19-701 of the Health - General Article OR A
26 COMMUNITY HEALTH NETWORK AS DEFINED IN § 19-2001 OF THE HEALTH -
27 GENERAL ARTICLE if the health care practitioner [does not have a beneficial interest in
28 the health care entity] IS REFERRING PATIENTS TO AN AFFILIATED HEALTH CARE
29 PROVIDER OF THE HEALTH MAINTENANCE ORGANIZATION OR COMMUNITY
30 HEALTH NETWORK;

31 (2) A health care practitioner who refers a patient to another health care
32 practitioner in the same group practice as the referring health care practitioner;

33 (3) A health care practitioner with a beneficial interest in a health care
34 entity who refers a patient to that health care entity for health care services or tests, if the
35 services or tests are personally performed by or under the direct supervision of the
36 referring health care practitioner;

1 (4) A health care practitioner who refers in-office ancillary services or tests
2 that are:

3 (i) Personally furnished by:

4 1. The referring health care practitioner;

5 2. A health care practitioner in the same group practice as the
6 referring health care practitioner; or

7 3. An individual who is employed and personally supervised by
8 the qualified referring health care practitioner or a health care practitioner in the same
9 group practice as the referring health care practitioner;

10 (ii) Provided in the same building where the referring health care
11 practitioner or a health care practitioner in the same group practice as the referring
12 health care practitioner furnishes services; and

13 (iii) Billed by:

14 1. The health care practitioner performing or supervising the
15 services; or

16 2. A group practice of which the health care practitioner
17 performing or supervising the services is a member;

18 (5) A health care practitioner who has a beneficial interest in a health care
19 entity if, in accordance with regulations adopted by the Secretary:

20 (i) The Secretary determines that the health care practitioner's
21 beneficial interest is essential to finance and to provide the health care entity; and

22 (ii) The Secretary, in conjunction with the Health Resources Planning
23 Commission, determines that the health care entity is needed to ensure appropriate
24 access for the community to the services provided at the health care entity;

25 (6) A health care practitioner employed or affiliated with a hospital, who
26 refers a patient to a health care entity that is owned or controlled by a hospital or under
27 common ownership or control with a hospital if the health care practitioner does not have
28 a direct beneficial interest in the health care entity;

29 (7) A health care practitioner or member of a single specialty group
30 practice, including any person employed or affiliated with a hospital, who has a beneficial
31 interest in a health care entity that is owned or controlled by a hospital or under common
32 ownership or control with a hospital if:

33 (i) The health care practitioner or other member of that single
34 specialty group practice provides the health care services to a patient pursuant to a
35 referral or in accordance with a consultation requested by another health care
36 practitioner who does not have a beneficial interest in the health care entity; or

37 (ii) The health care practitioner or other member of that single
38 specialty group practice referring a patient to the facility, service, or entity personally
39 performs or supervises the health care service or procedure; or

1 (8) A health care practitioner with a beneficial interest in, or compensation
2 arrangement with, a hospital or related institution as defined in § 19-301 of the Health -
3 General Article or a facility, service, or other entity that is owned or controlled by a
4 hospital or related institution or under common ownership or control with a hospital or
5 related institution if:

6 (i) The beneficial interest was held or the compensation arrangement
7 was in existence on January 1, 1993; and

8 (ii) Thereafter the beneficial interest or compensation arrangement of
9 the health care practitioner does not increase.

10 14-501.

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

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

14 (ii) "Alternative health care system" includes:

15 1. A health maintenance organization;

16 2. A preferred provider organization;

17 3. A COMMUNITY HEALTH NETWORK, AS DEFINED IN §
18 19-2001 OF THE HEALTH - GENERAL ARTICLE;

19 [3.] 4. An independent practice association; or

20 [4.] 5. A community health center that is a nonprofit,
21 freestanding ambulatory health care provider governed by a voluntary board of directors
22 and that provides primary health care services to the medically indigent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (9) A committee appointed by or established in an accredited health
23 occupations school; or

24 (10) An organization described under § 14-501.1 of this subtitle that
25 contracts with a hospital, related institution, or health maintenance organization to:

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

28 (ii) Assist a health maintenance organization in meeting the
29 requirements of Title 19, Subtitle 7 of the Health - General Article, the National
30 Committee for Quality Assurance (NCQA), or any other applicable credentialing law or
31 regulation.

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

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

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

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

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

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

7 (2) The proceedings, records, and files of a medical review committee are
8 confidential and are not discoverable and are not admissible in evidence in any civil
9 action arising out of matters that are being reviewed and evaluated by the medical review
10 committee if requested by the following:

11 (i) The Department of Health and Mental Hygiene to ensure
12 compliance with the provisions of § 19-319 of the Health - General Article;

13 (ii) A health maintenance organization to ensure compliance with the
14 provisions of Title 19, Subtitle 7 of the Health - General Article and applicable
15 regulations; or

16 (iii) A health maintenance organization to ensure compliance with the
17 National Committee for Quality Assurance (NCQA) credentialing requirements.

18 SECTION 2. AND BE IT FURTHER ENACTED, That the catchlines contained in
19 this Act are not law and may not be considered to have been enacted as a part of this Act.

20 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
21 October 1, 1997.