HOUSE BILL 2
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(PRE-FILED)

By: **Delegates Goldwater, Taylor, Guns, Busch, Dewberry, Hurson, Rawlings, Curran, Vallario, Hixson, Harrison, Menes, Kopp, Arnick, Owings, W. Baker, Barve, Benson, Billings, Branch, Cadden, Clagett, Conroy, Conway, C. Davis, Dembrow, Doory, Dypski, Finifter, Franchot, Frank, Frush, Fulton, Hammen, Hecht, Heller, Howard, Jones, Krysiak, Linton, Love, Mandel, Marriott, McIntosh, Minnick, V. Mitchell, Nathan-Pulliam, Patterson, Perry, Petzold, Pitkin, Preis, Rosenberg, Slade, Turner, Weir, Wood, and Workman**

Requested: November 15, 1997
Introduced and read first time: January 14, 1998
Assigned to: Environmental Matters and Economic Matters

A BILL ENTITLED

AN ACT concerning

Maryland Health Care Regulatory and Systems Reform Act

FOR the purpose of integrating, consolidating, and streamlining certain health care regulatory responsibilities and duties under the Maryland Health Care Access and Cost Commission; specifying the purpose of this Act; abolishing certain commissions that function in the Department of Health and Mental Hygiene; altering the duties, responsibilities, and functions of the Commission; establishing a Health Care Access and Cost Commission Fund; specifying the funding for the Fund; altering certain provisions of law related to health planning and development; repealing the requirement that a certificate of need be obtained for establishing certain health care facilities under certain circumstances; authorizing the Commission to adopt certain regulations to establish a certain method and mechanism to finance the cost of uncompensated care for the types of procedures and services provided by freestanding ambulatory surgical facilities under certain circumstances; altering a certain provision of law related to the development and implementation of a certain payment system by the Commission; repealing the Advisory Committee on Practice Parameters; transferring the administrative and enforcement responsibility for private review agents to the Insurance Commissioner; transferring the responsibility for investigating complaints involving health maintenance organizations from the Department of Health and Mental Hygiene to the Commission; requiring the Commission to conduct a certain study regarding the certificate of need program; requiring the Commission to contract with a certain entity to conduct a certain management study; specifying certain transitional provisions relating to the implementation of the provisions of this Act; providing for the accurate codification of the provisions of this Act; making certain technical and stylistic changes; defining certain terms; altering certain

definitions; providing for the effective date of certain provisions of this Act; and generally relating to the integrating, consolidation, and streamlining of certain health care regulatory responsibilities and duties.

BY repealing
Article - Health - General
Section 19-102 through 19-109, 19-121, and 19-122, the part "Part I. Health Planning and Development", and the subtitle "Subtitle 1. Comprehensive Health Planning"; 19-202 through 19-207.1, 19-208, and 19-222 and the subtitle "Subtitle 2. Health Services Cost Review Commission"; 19-1511, 19-1512, and 19-1515 and the subtitle "Subtitle 15. Maryland Health Care Access and Cost Commission"; and 19-1601 through 19-1606, inclusive, and the subtitle "Subtitle 16. Advisory Committee on Practice Parameters"
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY renumbering
Article - Health - General
Section 19-125 and 19-126 and the part "Part II. Deficiencies in Services and Facilities", respectively
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)
to be Section 2-108 and 2-109 and the part "Part II. Deficiencies in Services and Facilities", respectively
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY renumbering
Article - Health - General
Section 19-1502 through 19-1506, 19-1510, 19-101, 19-110 through 19-120, 19-123, 19-201, 19-209, 19-210, 19-207.3, 19-211 through 19-213, 19-216 through 19-219, 19-207.2, 19-220, 19-214, 19-215, 19-221, 19-1501, 19-1507 through 19-1509, 19-1516, 19-1513, and 19-1514, respectively
to be Section 19-103 through 19-107, 19-108; 19-112, 19-115 through 19-127, and 19-128 to be under the new part "Part II. Health Planning and Development"; 19-129, 19-131, 19-132, 19-133, 19-135 through 19-138, 19-139 through 19-142, 19-143, 19-144, 19-145, 19-146, and 19-147 to be under the new part "Part III. Health Care Facility Rate Setting"; 19-148, 19-149 through 19-151, 19-152, 19-153, and 19-154 to be under the new part "Part IV. Medical Care Data Collection", respectively
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY transferring

Article - Health - General
Section 19-1301 through 19-1305, inclusive, 19-1305.1, 19-1305.2, 19-1305.3, 19-1305.4, and 19-1306 through 19-1313, inclusive, and the subtitle "Subtitle 13. Private Review Agents", respectively
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)
to be
Article - Insurance
Section 15-10A-01 through 15-10A-18, inclusive, to be under the subtitle "Subtitle 10A. Private Review Agents", respectively
Annotated Code of Maryland
(1997 Volume)

BY repealing and reenacting, without amendments,
Article - Health - General
Section 2-101 to be under the new part "Part I. General Provisions"
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 2-106
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 2-109
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)
(As enacted by Section 2 of this Act)

BY adding to
Article - Health - General
Section 19-101, 19-102, 19-109 through 19-111 to be under the new part "Part I. Maryland Health Care Access and Cost Commission" and the new subtitle "Subtitle 1. Health Care Planning and Systems Regulation"; 19-113, 19-114, 19-130, 19-134, and 19-728(d)
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General

Section 19-103, 19-112, 19-116, 19-118, 19-119, 19-120, 19-121, 19-122, 19-124, 19-125, 19-126, 19-127, 19-129, 19-135, 19-136, 19-138, 19-139, 19-140, 19-142, 19-144, 19-146, 19-147, 19-148, 19-149, 19-150, and 19-151(b) and (c)
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)
(As enacted by Section 2 of this Act)

BY repealing and reenacting, without amendments,
Article - Health - General
Section 19-104, 19-105, 19-106, 19-107, 19-108, 19-115, 19-117, 19-123, 19-128, 19-131, 19-132, 19-133, 19-137, 19-141, 19-143, 19-145, 19-152, 19-153, and 19-154
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)
(As enacted by Section 2 of this Act)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-404, 19-406, 19-705.1(f)(5), 19-705.2, and 19-906
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-111 and 15-1001
Annotated Code of Maryland
(1997 Volume)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-10A-01, 15-10A-03, 15-10A-04, 15-10A-05(a) and (b), 15-10A-06(a), (e), and (g), 15-10A-07(a), 15-10A-09(e)(1), 15-10A-10, 15-10A-11, 15-10A-12, 15-10A-13, 15-10A-14, 15-10A-17(b), and 15-10A-18(a)
Annotated Code of Maryland
(1997 Volume)
(As enacted by Section 3 of this Act)

BY repealing and reenacting, with amendments,
Article 43C - Maryland Health and Higher Educational Facilities Authority
Section 16A
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Chapter 134 of the Acts of the General Assembly of 1997
Section 6

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 19-102 through 19-109, 19-121, and 19-122, the part "Part I. Health Planning and Development", and the subtitle "Subtitle 1. Comprehensive Health Planning"; 19-202 through 19-207.1, 19-208, and 19-222 and the subtitle "Subtitle 2. Health Services Cost Review Commission"; 19-1511, 19-1512, and 19-1515 and the subtitle "Subtitle 15. Maryland Health Care Access and Cost Commission"; and 19-1601 through 19-1606, inclusive, and the subtitle "Subtitle 16. Advisory Committee on Practice Parameters" of Article - Health - General of the Annotated Code of Maryland be repealed.

SECTION 2. AND BE IT FURTHER ENACTED, That Section(s) 19-125 and 19-126 and the part "Part II. Deficiencies in Services and Facilities"; 19-1502 through 19-1506, 19-1510, 19-101, 19-110 through 19-120, 19-123, 19-201, 19-209, 19-210, 19-207.3, 19-211 through 19-213, 19-216 through 19-219, 19-207.2, 19-220, 19-214, 19-215, 19-221, 19-1501, 19-1507 through 19-1509, 19-1516, 19-1513, and 19-1514, respectively, of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 2-108 and 2-109 and the part "Part II. Deficiencies in Services and Facilities"; 19-103 through 19-107, 19-108; 19-112, 19-115 through 19-127, and 19-128 to be under the new part "Part II. Health Planning and Development"; 19-129, 19-131, 19-132, 19-133, 19-135 through 19-138, 19-139 through 19-142, 19-143, 19-144, 19-145, 19-146, and 19-147 to be under the new part "Part III. Health Care Facility Rate Setting"; and 19-148, 19-149 through 19-151, 19-152, 19-153, and 19-154 to be under the new part "Part IV. Medical Care Data Collection", respectively.

SECTION 3. AND BE IT FURTHER ENACTED, That Section(s) 19-1301 through 19-1305, inclusive, 19-1305.1, 19-1305.2, 19-1305.3, 19-1305.4, and 19-1306 through 19-1313, inclusive, and the subtitle "Subtitle 13. Private Review Agents", respectively, of the Article - Health - General of the Annotated Code of Maryland be transferred to be Section(s) 15-10A-01 through 15-10A-18, inclusive, and the subtitle "Subtitle 10A. Private Review Agents", respectively, of Article - Insurance of the Annotated Code of Maryland.

SECTION 4. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

PART I. GENERAL PROVISIONS.

2-101.

There is a Department of Health and Mental Hygiene, established as a principal department of the State government.

2-106.

(a) The following units are in the Department:

(1) Alcohol and Drug Abuse Administration.

(2) Anatomy Board.

(3) Developmental Disabilities Administration.

(4) [State Health Resources Planning Commission.

(5) Health Services Cost Review Commission.

(6)] Maryland Psychiatric Research Center.

[(7)] (5) Mental Hygiene Administration.

[(8)] (6) Postmortem Examiners Commission.

[(9)] (7) Board of Examiners for Audiologists.

[(10)] (8) Board of Chiropractic Examiners.

[(11)] (9) Board of Dental Examiners.

[(12)] (10) Board of Dietetic Practice.

[(13)] (11) Board of Electrologists.

[(14)] (12) Board of Morticians.

[(15)] (13) Board of Nursing.

[(16)] (14) Board of Examiners of Nursing Home Administrators.

[(17)] (15) Board of Occupational Therapy Practice.

[(18)] (16) Board of Examiners in Optometry.

[(19)] (17) Board of Pharmacy.

[(20)] (18) Board of Physical Therapy Examiners.

[(21)] (19) Board of Physician Quality Assurance.

[(22)] (20) Board of Podiatry Examiners.

[(23)] (21) Board of Examiners of Professional Counselors.

[(24)] (22) Board of Examiners of Psychologists.

[(25)] (23) Board of Social Work Examiners.

[(26)] (24) Board of Examiners for Speech-Language Pathologists.

[(27)] (25) Commission on Physical Fitness.

[(28) Advisory Board on Hospital Licensing.]

[(29)] (26) State Advisory Council on Alcohol and Drug Abuse.

[(30)] (27) Advisory Council on Infant Mortality.

(b) The Department also includes every other unit that is in the Department under any other law.

(c) The Secretary has the authority and powers specifically granted to the Secretary by law over the units in the Department. All authority and powers not so granted to the Secretary are reserved to those units free of the control of the Secretary.

Part II. Deficiencies in Services and Facilities.

2-109.

(a) In conjunction with the powers of the Secretary under [§ 19-125] § 2-108 of this subtitle, and in cooperation with the HEALTH CARE ACCESS AND COST Commission, the Secretary shall make an assessment of health care deficiencies in Worcester County.

(b) The assessment shall include the following:

(1) The availability of efficient health care services and providers;

(2) The identification of unmet needs, including those which may result from seasonal variations in population;

(3) Access to health care, including an analysis of travel times and other factors;

(4) The need for specific services, such as emergency care;

(5) An evaluation of alternative means of providing care typically provided in the acute hospital setting;

(6) Methods of configuring the health care services of Worcester County with existing health care providers; and

(7) Financial and manpower resources required and available.

(c) The Secretary shall report the findings of the assessment to the Joint Committee on Health Care Cost Containment on or before November 1, 1986.

(d) In cooperation with appropriate county and State groups, the Secretary shall develop recommendations to implement the findings of the assessment.

(e) The Secretary shall report to the General Assembly on February 1, 1987, on the progress towards implementation of the recommendations.

(f) The HEALTH CARE ACCESS AND COST Commission shall include standards and policies in the State health plan that relate to the Secretary's recommendations.

SUBTITLE 1. HEALTH CARE PLANNING AND SYSTEMS REGULATION.

PART I. MARYLAND HEALTH CARE ACCESS AND COST COMMISSION.

19-101.

IN THIS SUBTITLE, "COMMISSION" MEANS THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION.

19-102.

(A) THE GENERAL ASSEMBLY FINDS THAT THE HEALTH CARE REGULATORY SYSTEM IN THIS STATE IS A HIGHLY COMPLEX STRUCTURE THAT NEEDS TO BE CONSTANTLY REEVALUATED AND MODIFIED IN ORDER TO BETTER REFLECT AND BE MORE RESPONSIVE TO THE EVER CHANGING HEALTH CARE ENVIRONMENT AND THE NEEDS OF THE CITIZENS OF THIS STATE.

(B) THE PURPOSE OF THIS SUBTITLE IS TO ESTABLISH A STREAMLINED HEALTH CARE REGULATORY SYSTEM IN THIS STATE IN A MANNER SUCH THAT A SINGLE STATE HEALTH POLICY CAN BE BETTER ARTICULATED, COORDINATED, AND IMPLEMENTED IN ORDER TO BETTER SERVE THE CITIZENS OF THIS STATE.

19-103.

(a) There is a Maryland Health Care Access and Cost Commission.

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

(c) The purpose of the Commission is to:

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

(2) PROMOTE THE DEVELOPMENT OF A HEALTH CARE SYSTEM THAT PROVIDES, FOR ALL CITIZENS, FINANCIAL AND GEOGRAPHIC ACCESS TO QUALITY HEALTH CARE SERVICES AT A REASONABLE COST BY:

(I) PLANNING TO MEET THE CURRENT AND FUTURE HEALTH CARE NEEDS OF THE CITIZENS OF THIS STATE;

(II) IDENTIFYING THE RESOURCES ESSENTIAL TO MEET THOSE DEFINED NEEDS;

(III) PROMOTING THROUGH PLANS AND POLICIES THE APPROPRIATE USE OF THE RESOURCES ESSENTIAL TO MEET THOSE DEFINED NEEDS;

(IV) ADVOCATING POLICIES AND SYSTEMS TO PROMOTE THE EFFICIENT DELIVERY OF AND IMPROVED ACCESS TO HEALTH CARE SERVICES;

(V) ENHANCING THE STRENGTHS OF THE CURRENT HEALTH CARE SERVICE DELIVERY AND REGULATORY SYSTEMS AND CORRECTING THEIR WEAKNESSES;

(VI) CONSIDERING THE PLANS AND PROGRAMS OF STATE AGENCIES AND DEPARTMENTS AND ASSURING CONSISTENCY WITH POLICIES AND PRIORITIES OF SUCH AGENCIES AND DEPARTMENTS IN PREPARATION OF THE STATE HEALTH PLAN; AND

(VII) PROVIDING FOR ASSESSMENT OF THE IMPACT OF PLANS AND PROJECTS ON TOTAL HEALTH CARE COSTS TO THIS STATE AND ITS CITIZENS;

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

[(3)] (4) Establish and develop a medical care data base on health care services rendered by health care practitioners;

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

[(5)] (6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop:

(i) A uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan; and

(ii) A modified health benefit plan for medical savings accounts;

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

[(7)] (8) Ensure utilization of the medical care data base as a primary means to compile data and information and annually report on trends and variances

regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

[(8)] (9) Develop a payment system for health care services;

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

(11) INVESTIGATE COMPLAINTS INVOLVING HEALTH MAINTENANCE ORGANIZATIONS IN ACCORDANCE WITH SUBTITLE 7 OF THIS TITLE;

[(10) Foster the development of practice parameters;]

[(11)] (12) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors; and

[(12)] (13) Develop a uniform set of effective benefits to be offered as substantial, available, and affordable coverage in the nongroup market in accordance with § 15-606 of the Insurance Article.

19-104.

(a) (1) The Commission shall consist of nine members appointed by the Governor with the advice and consent of the Senate.

(2) Of the nine members, six shall be individuals who do not have any connection with the management or policy of a health care provider or payor.

(b) (1) The term of a member is 4 years.

(2) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies.

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

(4) A member may not serve more than two consecutive terms.

(c) (1) Except as provided in paragraph (2) of this subsection, to the extent practicable, when appointing members to the Commission, the Governor shall assure geographic balance in the Commission's membership.

(2) Two members of the Commission shall be appointed at large and may be from a geographic area already represented on the Commission.

19-105.

(a) The Governor shall appoint the chairman of the Commission.

(b) The chairman may appoint a vice chairman for the Commission.

19-106.

(a) With the approval of the Governor, the Commission shall appoint an executive director who shall be the chief administrative officer of the Commission.

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

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

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

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

19-107.

(a) A majority of the full authorized membership of the Commission is a quorum. However, the Commission may not act on any matter unless at least four of the voting members in attendance concur.

(b) The Commission shall meet at least six times each year, at the times and places that it determines.

(c) Each member of the Commission is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

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

19-108.

(a) In addition to the duties set forth elsewhere in this subtitle, the Commission shall adopt regulations specifying the comprehensive standard health benefit plan to apply under Title 15, Subtitle 12 of the Insurance Article.

(b) In carrying out its duties under this section, the Commission shall comply with the provisions of § 15-1207 of the Insurance Article.

19-109.

(A) IN ADDITION TO THE POWERS SET FORTH ELSEWHERE IN THIS SUBTITLE, THE COMMISSION MAY:

(1) ADOPT RULES AND REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SUBTITLE;

(2) CREATE COMMITTEES FROM AMONG ITS MEMBERS;

(3) APPOINT ADVISORY COMMITTEES, WHICH MAY INCLUDE INDIVIDUALS AND REPRESENTATIVES OF INTERESTED PUBLIC OR PRIVATE ORGANIZATIONS;

(4) APPLY FOR AND ACCEPT ANY FUNDS, PROPERTY, OR SERVICES FROM ANY PERSON OR GOVERNMENT AGENCY;

(5) MAKE AGREEMENTS WITH A GRANTOR OR PAYOR OF FUNDS, PROPERTY, OR SERVICES, INCLUDING AN AGREEMENT TO MAKE ANY STUDY, PLAN, DEMONSTRATION, OR PROJECT;

(6) PUBLISH AND GIVE OUT ANY INFORMATION THAT RELATES TO THE FINANCIAL ASPECTS OF HEALTH CARE AND IS CONSIDERED DESIRABLE IN THE PUBLIC INTEREST; AND

(7) SUBJECT TO THE LIMITATIONS OF THIS SUBTITLE, EXERCISE ANY OTHER POWER THAT IS REASONABLY NECESSARY TO CARRY OUT THE PURPOSES OF THIS SUBTITLE.

(B) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS SUBTITLE, THE COMMISSION SHALL:

(1) ADOPT RULES AND REGULATIONS THAT RELATE TO ITS MEETINGS, MINUTES, AND TRANSACTIONS;

(2) KEEP MINUTES OF EACH MEETING;

(3) PREPARE ANNUALLY A BUDGET PROPOSAL THAT INCLUDES THE ESTIMATED INCOME OF THE COMMISSION AND PROPOSED EXPENSES FOR ITS ADMINISTRATION AND OPERATION;

(4) BEGINNING JULY 1, 1999, AND EACH JULY 1 THEREAFTER, SUBMIT TO THE GOVERNOR, TO THE SECRETARY, AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY AN ANNUAL REPORT ON THE OPERATIONS AND ACTIVITIES OF THE COMMISSION DURING THE PRECEDING FISCAL YEAR, INCLUDING:

(I) A COPY OF EACH SUMMARY, COMPILATION, AND SUPPLEMENTARY REPORT REQUIRED BY THIS SUBTITLE; AND

(II) ANY OTHER FACT, SUGGESTION, OR POLICY RECOMMENDATION THAT THE COMMISSION CONSIDERS NECESSARY; AND

(5) EXCEPT FOR CONFIDENTIAL OR PRIVILEGED MEDICAL OR PATIENT INFORMATION, THE COMMISSION SHALL MAKE:

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

(II) EACH SUMMARY, COMPILATION, AND REPORT AVAILABLE TO ANY OTHER STATE AGENCY ON REQUEST.

(C) (1) THE COMMISSION MAY CONTRACT WITH A QUALIFIED, INDEPENDENT THIRD PARTY FOR ANY SERVICE NECESSARY TO CARRY OUT THE POWERS AND DUTIES OF THE COMMISSION.

(2) UNLESS PERMISSION IS GRANTED SPECIFICALLY BY THE COMMISSION, A THIRD PARTY HIRED BY THE COMMISSION MAY NOT RELEASE, PUBLISH, OR OTHERWISE USE ANY INFORMATION TO WHICH THE THIRD PARTY HAS ACCESS UNDER ITS CONTRACT.

19-110.

(A) EXCEPT AS EXPRESSLY PROVIDED IN THIS SUBTITLE, THE POWER OF THE SECRETARY OVER PLANS, PROPOSALS, AND PROJECTS OF UNITS IN THE DEPARTMENT DOES NOT INCLUDE THE POWER TO DISAPPROVE OR MODIFY ANY REGULATION, DECISION, OR DETERMINATION THAT THE COMMISSION MAKES UNDER AUTHORITY SPECIFICALLY DELEGATED BY LAW TO THE COMMISSION.

(B) THE POWER OF THE SECRETARY TO TRANSFER, BY RULE, REGULATION, OR WRITTEN DIRECTIVE, ANY STAFF, FUNCTIONS, OR FUNDS OF UNITS IN THE DEPARTMENT DOES NOT APPLY TO ANY STAFF, FUNCTION, OR FUNDS OF THE COMMISSION.

19-111.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "FUND" MEANS THE HEALTH CARE ACCESS AND COST COMMISSION FUND.

(3) "HEALTH CARE PRACTITIONER" MEANS ANY INDIVIDUAL WHO PROVIDES HEALTH CARE SERVICES AND IS LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE.

(4) "NURSING HOME" MEANS A RELATED INSTITUTION THAT IS CLASSIFIED AS A NURSING HOME.

(5) "PAYOR" MEANS:

(I) A HEALTH INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT HOLDS A CERTIFICATE OF AUTHORITY AND PROVIDES HEALTH INSURANCE POLICIES OR CONTRACTS IN THE STATE IN ACCORDANCE WITH THIS ARTICLE OR THE INSURANCE ARTICLE;

(II) A HEALTH MAINTENANCE ORGANIZATION THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE STATE; OR

(III) A THIRD PARTY ADMINISTRATOR AS DEFINED IN § 15-111 OF THE INSURANCE ARTICLE.

(B) SUBJECT TO THE PROVISIONS OF SUBSECTION (D) OF THIS SECTION, THE COMMISSION SHALL ASSESS A FEE ON:

(1) ALL HOSPITALS;

(2) ALL NURSING HOMES;

(3) ALL PAYORS; AND

(4) ALL HEALTH CARE PRACTITIONERS.

(C) (1) THE TOTAL FEES ASSESSED BY THE COMMISSION MAY NOT EXCEED $11,000,000 IN ANY FISCAL YEAR.

(2) THE FEES ASSESSED BY THE COMMISSION SHALL BE USED EXCLUSIVELY TO COVER THE ACTUAL DOCUMENTED DIRECT AND INDIRECT COSTS OF FULFILLING THE STATUTORY AND REGULATORY DUTIES OF THE COMMISSION IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBTITLE.

(3) THE COMMISSION SHALL PAY ALL FUNDS COLLECTED FROM THE FEES ASSESSED IN ACCORDANCE WITH THIS SECTION INTO THE FUND.

(4) THE FEES ASSESSED MAY BE EXPENDED ONLY FOR PURPOSES AUTHORIZED BY THE PROVISIONS OF THIS SUBTITLE.

(D) FROM THE TOTAL FEES TO BE ASSESSED BY THE COMMISSION UNDER SUBSECTION (C)(1) OF THIS SECTION, THE COMMISSION:

(1) IN LIEU OF THE APPLICATION FEES PROVIDED FOR IN § 19-120 OF THIS SUBTITLE, SHALL ASSESS:

(I) HOSPITALS AND SPECIAL HOSPITALS FOR A TOTAL AMOUNT NOT EXCEEDING $5,500,000 IN ANY FISCAL YEAR; AND

(II) NURSING HOMES FOR A TOTAL AMOUNT NOT EXCEEDING $1,500,000 IN ANY FISCAL YEAR;

(2) SHALL ASSESS PAYORS FOR A TOTAL AMOUNT NOT EXCEEDING $3,250,000 IN ANY FISCAL YEAR; AND

(3) SHALL ASSESS HEALTH CARE PRACTITIONERS FOR AN AMOUNT NOT EXCEEDING $750,000 IN ANY FISCAL YEAR.

(E) (1) THE FEES ASSESSED IN ACCORDANCE WITH THIS SECTION ON HEALTH CARE PRACTITIONERS SHALL BE:

(I) INCLUDED IN THE LICENSING FEE PAID TO THE HEALTH CARE PRACTITIONER'S LICENSING BOARD; AND

(II) TRANSFERRED BY THE HEALTH CARE PRACTITIONER'S LICENSING BOARD TO THE COMMISSION ON A QUARTERLY BASIS.

(2) THE COMMISSION MAY ADOPT REGULATIONS THAT WAIVE THE FEE ASSESSED UNDER THIS SECTION FOR A SPECIFIC CLASS OF HEALTH CARE PRACTITIONERS.

(F) (1) THERE IS A HEALTH CARE ACCESS AND COST COMMISSION FUND.

(2) THE FUND IS A SPECIAL CONTINUING, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7-302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(3) THE TREASURER SHALL SEPARATELY HOLD, AND THE COMPTROLLER SHALL ACCOUNT FOR, THE FUND.

(4) THE FUND SHALL BE INVESTED AND REINVESTED IN THE SAME MANNER AS OTHER STATE FUNDS.

(5) ANY INVESTMENT EARNINGS SHALL BE RETAINED TO THE CREDIT OF THE FUND.

(6) THE FUND SHALL BE SUBJECT TO AN AUDIT BY THE OFFICE OF LEGISLATIVE AUDITS AS PROVIDED FOR IN § 2-1220 OF THE STATE GOVERNMENT ARTICLE.

(7) THIS SECTION MAY NOT BE CONSTRUED TO PROHIBIT THE FUND FROM RECEIVING FUNDS FROM ANY OTHER SOURCE.

(8) THE FUND SHALL BE USED ONLY TO PROVIDE FUNDING FOR THE COMMISSION AND FOR THE PURPOSES AUTHORIZED UNDER THIS SUBTITLE.

(G) THE COMMISSION SHALL:

(1) (I) ASSESS FEES ON PAYORS IN ACCORDANCE WITH § 15-111 OF THE INSURANCE ARTICLE AND IN A MANNER THAT APPORTIONS THE TOTAL AMOUNT OF THE FEES TO BE ASSESSED ON PAYORS UNDER SUBSECTION (D)(2) OF THIS SECTION AMONG EACH PAYOR BASED ON THE RATIO OF EACH SUCH PAYOR'S TOTAL PREMIUMS COLLECTED IN THE STATE TO THE TOTAL COLLECTED PREMIUMS OF ALL SUCH PAYORS COLLECTED IN THE STATE; AND

(II) ON OR BEFORE JUNE 1 OF EACH YEAR, NOTIFY THE INSURANCE COMMISSIONER BY MEMORANDUM OF THE TOTAL ASSESSMENT ON PAYORS FOR THAT YEAR; AND

(2) (I) ASSESS FEES FOR EACH HOSPITAL EQUAL TO THE SUM OF:

1. THE AMOUNT EQUAL TO ONE-HALF OF THE TOTAL FEES TO BE ASSESSED ON HOSPITALS UNDER SUBSECTION (D)(1)(I) OF THIS SECTION TIMES THE RATIO OF ADMISSIONS TO THE HOSPITAL TO TOTAL ADMISSIONS OF ALL HOSPITALS; AND

2. THE AMOUNT EQUAL TO ONE-HALF OF THE TOTAL FEES TO BE ASSESSED ON HOSPITALS UNDER SUBSECTION (D)(1)(I) OF THIS SUBSECTION TIMES THE RATIO OF GROSS OPERATING REVENUE OF EACH HOSPITAL TO TOTAL GROSS OPERATING REVENUES OF ALL HOSPITALS;

(II) ASSESS FEES FOR EACH NURSING HOME EQUAL TO THE SUM OF:

1. THE AMOUNT EQUAL TO ONE-HALF OF THE TOTAL FEES TO BE ASSESSED ON NURSING HOMES UNDER SUBSECTION (D)(1)(II) OF THIS SECTION TIMES THE RATIO OF ADMISSIONS TO THE NURSING HOME TO TOTAL ADMISSIONS OF ALL NURSING HOMES; AND

2. THE AMOUNT EQUAL TO ONE-HALF OF THE TOTAL FEES TO BE ASSESSED ON NURSING HOMES UNDER SUBSECTION (D)(1)(II) OF THIS SECTION TIMES THE RATIO OF GROSS OPERATING REVENUE OF EACH NURSING HOME TO TOTAL GROSS OPERATING REVENUES OF ALL NURSING HOMES;

(III) ESTABLISH MINIMUM AND MAXIMUM ASSESSMENTS; AND

(IV) ASSESS EACH HOSPITAL AND NURSING HOME ON OR BEFORE JUNE 30 OF EACH FISCAL YEAR.

(H) (1) ON OR BEFORE SEPTEMBER 1 OF EACH YEAR, EACH HOSPITAL AND NURSING HOME ASSESSED UNDER THIS SECTION SHALL MAKE PAYMENT TO THE COMMISSION.

(2) THE COMMISSION SHALL MAKE PROVISIONS FOR PARTIAL PAYMENTS.

(I) ANY BILL NOT PAID WITHIN 30 DAYS OF THE AGREED PAYMENT DATE MAY BE SUBJECT TO AN INTEREST PENALTY TO BE DETERMINED BY THE COMMISSION.

PART II. HEALTH PLANNING AND DEVELOPMENT.

19-112.

(a) In [Part I] THIS PART II of this subtitle the following words have the meanings indicated.

(b) (1) "Ambulatory surgical facility" means any center, service, office, facility, or office of one or more health care practitioners or a group practice, as defined in § 1-301 of the Health Occupations Article, that:

(i) Has two or more operating rooms;

(ii) Operates primarily for the purpose of providing surgical services to patients who do not require overnight hospitalization; and

(iii) Seeks reimbursement from payors as an ambulatory surgical facility.

(2) For purposes of this subtitle, the office of one or more health care practitioners or a group practice with two operating rooms may be exempt from the certificate of need requirements under this subtitle if the Commission finds, in its sole discretion, that:

(i) A second operating room is necessary to promote the efficiency, safety, and quality of the surgical services offered; and

(ii) The office meets the criteria for exemption from the certificate of need requirements as an ambulatory surgical facility in accordance with regulations adopted by the Commission.

(c) "Certificate of need" means a certification of public need issued by the Commission under this [subtitle] PART II OF THIS SUBTITLE for a health care project.

(d) ["Commission" means the State Health Resources Planning Commission.

(e)] "Federal Act" means the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), as amended.

[(f)] (E) (1) "Health care facility" means:

(i) A hospital, as defined in § 19-301 of this title;

(ii) A related institution, as defined in § 19-301 of this title;

(iii) An ambulatory surgical facility;

(iv) An inpatient facility that is organized primarily to help in the rehabilitation of disabled individuals, through an integrated program of medical and other services provided under competent professional supervision;

(v) A home health agency, as defined in § 19-401 of this title;

(vi) A hospice, as defined in § 19-901 of this title; and

(vii) Any other health institution, service, or program for which [Part I] THIS PART II of this subtitle requires a certificate of need.

(2) "Health care facility" does not include:

(i) A hospital or related institution that is operated, or is listed and certified, by the First Church of Christ Scientist, Boston, Massachusetts;

(ii) For the purpose of providing an exemption from a certificate of need under [§ 19-115] § 19-121 of this subtitle, a facility to provide comprehensive care constructed by a provider of continuing care, as defined by Article 70B of the Code, if:

1. The facility is for the exclusive use of the provider's subscribers who have executed continuing care agreements for the purpose of utilizing independent living units or domiciliary care within the continuing care facility;

2. The number of comprehensive care nursing beds in the facility does not exceed 20 percent of the number of independent living units at the continuing care community; and

3. The facility is located on the campus of the continuing care facility;

(iii) Except for a facility to provide kidney transplant services or programs, a kidney disease treatment facility, as defined by rule or regulation of the United States Department of Health and Human Services;

(iv) Except for kidney transplant services or programs, the kidney disease treatment stations and services provided by or on behalf of a hospital or related institution; or

(v) The office of one or more individuals licensed to practice dentistry under Title 4 of the Health Occupations Article, for the purposes of practicing dentistry.

[(g)] (F) "Health care practitioner" means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide medical services in the ordinary course of business or practice of a profession.

[(h)] (G) "Health service area" means an area of this State that the Governor designates as appropriate for planning and developing of health services.

[(i)] (H) "Local health planning agency" means a body that the Commission designates to perform health planning and development functions for a health service area.

19-113.

(A) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS SUBTITLE, IN THIS PART II OF THIS SUBTITLE, THE COMMISSION SHALL:

(1) ACT AS THE STATE AGENCY TO REPRESENT THE STATE UNDER TITLE VI OF THE FEDERAL PUBLIC HEALTH SERVICE ACT; AND

(2) PERIODICALLY PARTICIPATE IN OR PERFORM ANALYSES AND STUDIES THAT RELATE TO:

(I) ADEQUACY OF SERVICES AND FINANCIAL RESOURCES TO MEET THE NEEDS OF THE POPULATION;

(II) DISTRIBUTION OF HEALTH CARE RESOURCES;

(III) ALLOCATION OF HEALTH CARE RESOURCES;

(IV) COSTS OF HEALTH CARE IN RELATIONSHIP TO AVAILABLE FINANCIAL RESOURCES; OR

(V) ANY OTHER APPROPRIATE MATTER.

(B) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS PART II OF THIS SUBTITLE, THE GOVERNOR SHALL DIRECT, AS NECESSARY, A STATE OFFICER OR AGENCY TO COOPERATE IN CARRYING OUT THE FUNCTIONS OF THE COMMISSION.

(C) THIS STATE RECOGNIZES THE FEDERAL ACT AND ANY AMENDMENT TO THE FEDERAL ACT THAT DOES NOT REQUIRE STATE LEGISLATION TO BE EFFECTIVE. HOWEVER, IF THE FEDERAL ACT IS REPEALED OR EXPIRES, THIS PART II OF THIS SUBTITLE REMAINS IN EFFECT.

19-114.

(A) (1) THE COMMISSION SHALL PROVIDE FOR A STUDY OF SYSTEMS CAPACITY IN HEALTH SERVICES.

(2) THE STUDY SHALL:

(I) DETERMINE FOR ALL HEALTH DELIVERY FACILITIES AND SETTINGS WHERE CAPACITY SHOULD BE INCREASED OR DECREASED TO BETTER MEET THE NEEDS OF THE POPULATION;

(II) EXAMINE AND DESCRIBE THE IMPLEMENTATION METHODS AND TOOLS BY WHICH CAPACITY SHOULD BE ALTERED TO BETTER MEET THE NEEDS; AND

(III) ASSESS THE IMPACT OF THOSE METHODS AND TOOLS ON THE COMMUNITIES AND HEALTH CARE DELIVERY SYSTEM.

(B) (1) IN ADDITION TO INFORMATION THAT AN APPLICANT FOR A CERTIFICATE OF NEED MUST PROVIDE, THE COMMISSION MAY REQUEST, COLLECT, AND REPORT ANY STATISTICAL OR OTHER INFORMATION THAT:

(I) IS NEEDED BY THE COMMISSION TO PERFORM ITS DUTIES DESCRIBED IN THIS PART II OF THIS SUBTITLE; AND

(II) IS DESCRIBED IN RULES AND REGULATIONS OF THE COMMISSION.

(2) IF A HEALTH CARE FACILITY FAILS TO PROVIDE INFORMATION AS REQUIRED IN THIS SUBSECTION, THE COMMISSION MAY:

(I) IMPOSE A PENALTY OF NOT MORE THAN $100 PER DAY FOR EACH DAY THE VIOLATION CONTINUES AFTER CONSIDERATION OF THE

WILLFULNESS AND SERIOUSNESS OF THE WITHHOLDING AS WELL AS ANY PAST HISTORY OF WITHHOLDING OF INFORMATION;

(II) ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES THE APPLICANT TO PROVIDE THE INFORMATION; OR

(III) APPLY TO THE CIRCUIT COURT IN THE COUNTY IN WHICH THE FACILITY IS LOCATED FOR LEGAL RELIEF CONSIDERED APPROPRIATE BY THE COMMISSION.

(3) THE COMMISSION MAY SEND TO A LOCAL HEALTH PLANNING AGENCY ANY STATISTICAL OR OTHER INFORMATION THE COMMISSION IS AUTHORIZED TO COLLECT UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(C) (1) AS EARLY AS POSSIBLE, BUT AT LEAST 60 DAYS BEFORE THE SECRETARY SUBMITS TO THE GOVERNOR THE ANNUAL REVISION OF THE DEPARTMENT'S EXECUTIVE PLAN, THE SECRETARY SHALL SUBMIT THE PROGRAM PLAN AND BUDGETARY PRIORITIES IN THE PLAN TO THE COMMISSION FOR REVIEW AND COMMENT.

(2) THE COMMISSION SHALL:

(I) SEND TO EACH LOCAL HEALTH PLANNING AGENCY FOR REVIEW AND COMMENT A COPY OF THE PROPOSED BUDGETARY PRIORITIES THAT AFFECT THE HEALTH SERVICE AREA FOR WHICH THE LOCAL HEALTH PLANNING AGENCY IS RESPONSIBLE; AND

(II) SUBMIT TO THE SECRETARY ITS COMMENTS ON THE PROPOSED PROGRAM AND BUDGETARY PRIORITIES IN SUFFICIENT TIME FOR THE SECRETARY TO CONSIDER THE COMMENTS PRIOR TO THIS SUBMISSION TO THE GOVERNOR.

19-115.

(a) In accordance with criteria that the Commission sets, the Governor shall designate health service areas in this State.

(b) After a 1-year period, the Governor may review or revise the boundaries of a health service area or increase the number of health service areas, on the Governor's initiative, at the request of the Commission, at the request of a local government, or at the request of a local health planning agency. Revisions to boundaries of health service areas shall be done in accordance with the criteria established by the Commission and with the approval of the legislature.

(c) Within 45 days of receipt of the State health plan or a change in the State health plan, the plan becomes effective unless the Governor notifies the Commission of his intent to modify or revise the State health plan adopted by the Commission.

19-116.

(a) The Commission shall designate, for each health service area, not more than 1 local health planning agency.

(B) Local health systems agencies shall be designated as the local health planning agency for a one-year period beginning October 1, 1982, provided that the local health systems agency has:

(1) Full or conditional designation by the federal government by October 1, 1982;

(2) The ability to perform the functions prescribed in subsection [(c)] (D) of this section; or

(3) Received the support of the local governments in the areas in which the agency is to operate.

[(b)] (C) The Commission shall establish by [regulations] REGULATION criteria for designation of local health planning agencies.

[(c)] (D) Applicants for designation as the local health planning agency shall, at a minimum, be able to:

(1) Assure broad citizen representation, including a board with a consumer majority;

(2) Develop a local health plan by assessing local health needs and resources, establishing local standards and criteria for service characteristics, consistent with State specifications, and setting local goals and objectives for systems development;

(3) Provide input into the development of statewide criteria and standards for certificate of need and health planning; and

(4) Provide input into evidentiary hearings on the evaluation of certificate of need applications from its area. Where no local health planning agency is designated, the Commission shall seek the advice of the local county government of the affected area.

[(d)] (E) The Commission shall require that in developing local health plans, each local health planning agency:

(1) Use the population estimates that the Department prepares under § 4-218 of this article;

(2) Use the figures and special age group projections that the Office of Planning prepares annually for the Commission;

(3) Meet applicable planning specifications; and

(4) Work with other local health planning agencies to ensure consistency among local health plans.

19-117.

Annually each local health planning agency shall receive the Department's program and budgetary priorities no later than July 1 and may submit to the Secretary comments on the proposed program and budgetary priorities within 60 days after receiving the proposals.

19-118.

(a) (1) The governing body or bodies of 1 or more adjacent counties that constitute a health service area may establish a body to serve as the local health planning agency for the health service area, by:

(i) Making a joint agreement as to the purpose, structure, and functions of the proposed body; and

(ii) Each enacting an ordinance that designates the proposed body to be the local health planning agency for the county.

(2) The body so established becomes the local health planning agency if the Commission designates the body as a health planning agency.

(b) The governing board shall exercise all of the powers of the local health planning agency that, by law, agreement of the counties, or bylaws of the local health planning agency, are not conferred on or reserved to the counties or to another structure within the local health planning agency.

(c) In addition to the powers set forth elsewhere in [Part I] THIS PART II of this subtitle, each local health planning agency created under this section may:

(1) Sue and be sued;

(2) Make contracts;

(3) Incur necessary obligations, which may not constitute the obligations of any county in the health service area;

(4) Acquire, hold, use, improve, and otherwise deal with property;

(5) Elect officers and appoint agents, define their duties, and set their compensation;

(6) Adopt and carry out an employee benefit plan;

(7) Adopt bylaws to conduct its affairs; and

(8) Use the help of any person or public agency to carry out the plans and policies of the local health planning agency.

(d) (1) In addition to the duties set forth elsewhere in [Part I] THIS PART II of this subtitle, each local health planning agency created under this section shall submit annually to the governing body of each county in the health service area a report on the activities of the local health planning agency.

(2) The report shall include an account of the funds, property, and expenses of the local health planning agency in the preceding year.

19-119.

(a) (1) At least every 5 years, beginning no later than October 1, 1983, the Commission shall adopt a State health plan that includes local health plans.

(2) The plan shall include:

(i) A description of the components that should comprise the health care system;

(ii) The goals and policies for Maryland's health care system;

(iii) Identification of unmet needs, excess services, minimum access criteria, and services to be regionalized;

(iv) An assessment of the financial resources required and available for the health care system;

(v) The methodologies, standards, and criteria for certificate of need review; and

(vi) Priority for conversion of acute capacity to alternative uses where appropriate.

(b) The Commission shall adopt specifications for the development of local health plans and their coordination with the State health plan.

(c) Annually or upon petition by any person, the Commission shall review the State health plan and publish any changes in the plan that the Commission considers necessary, subject to the review and approval granted to the Governor under this subtitle.

(d) The Commission shall adopt rules and regulations that ensure broad public input, public hearings, and consideration of local health plans in development of the State health plan.

(e) (1) The Commission shall include standards and policies in the State health plan that relate to the certificate of need program.

(2) The standards:

(I) [shall] SHALL address the availability, accessibility, cost, and quality of health care[. The standards]; AND

(II) [are] ARE to be reviewed and revised periodically to reflect new developments in health planning, delivery, and technology.

(3) In adopting standards regarding cost, efficiency, cost-effectiveness, or financial feasibility, the Commission may take into account the relevant methodologies [of the Health Services Cost Review Commission] USED UNDER PART III OF THIS SUBTITLE.

(f) Annually, the Secretary shall make recommendations to the Commission on the plan. The Secretary may review and comment on State specifications to be used in the development of the State health plan.

(g) All State agencies and departments, directly or indirectly involved with or responsible for any aspect of regulating, funding, or planning for the health care industry or persons involved in it, shall carry out their responsibilities in a manner consistent with the State health plan and available fiscal resources.

(h) In carrying out its responsibilities under this [Act] PART II OF THIS SUBTITLE for hospitals, the Commission shall recognize [and], BUT MAY not apply, [not] develop, or [not] duplicate standards or requirements related to quality which have been adopted and enforced by national or State licensing or accrediting authorities.

19-120.

(a) The Commission shall develop and adopt an institution-specific plan to guide possible capacity reduction.

(b) The institution-specific plan shall address:

(1) Accurate bed count data for licensed beds and staffed and operated beds:

(I) WHICH FOR HOSPITALS WITH 100 OR MORE AUTHORIZED BEDS AS OF JANUARY 1, 1997, SHALL BE 120% OF THE AVERAGE DAILY CENSUS FOR THE YEAR 1997; AND

(II) WHICH FOR HOSPITALS WITH FEWER THAN 100 AUTHORIZED BEDS AS OF JANUARY 1, 1997, SHALL BE 130% OF THE AVERAGE DAILY CENSUS FOR THE YEAR 1997;

(2) Cost data associated with all hospital beds and associated services on a hospital-specific basis;

(3) Migration patterns and current and future projected population data;

(4) Accessibility and availability of beds;

(5) Quality of care;

(6) Current health care needs, as well as growth trends for such needs, for the area served by each hospital;

(7) Hospitals in high growth areas; and

(8) Utilization.

(c) In the development of the institution-specific plan the Commission shall give priority to the conversion of acute capacity to alternative uses where appropriate.

(d) (1) The Commission shall use the institution-specific plan in reviewing certificate of need applications for conversion, expansion, consolidation, or introduction of hospital services in conjunction with the State health plan.

(2) If there is a conflict between the State health plan and any rule or regulation adopted by the Commission in accordance with Title 10, Subtitle 1 of the State Government Article to implement an institution-specific plan that is developed for identifying any excess capacity in beds and services, the provisions of whichever plan that is most recently adopted shall control.

(3) Immediately upon adoption of the institution-specific plan the [Health Resources Planning] Commission shall begin the process of incorporating the institution-specific plan into the State health plan and shall complete the incorporation within 12 months.

(4) A State health plan developed or adopted after the incorporation of the institution-specific plan into the State health plan shall include the criteria in subsection (b) of this section in addition to the criteria in [§ 19-114 of this article] § 19-119 OF THIS SUBTITLE.

19-121.

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

(2) (I) "Health care service" means any clinically-related patient service [including].

(II) "HEALTH CARE SERVICE" INCLUDES a medical service [under paragraph (3) of this subsection].

(3) "Medical service" means:

(i) Any of the following categories of health care services:

1. Medicine, surgery, gynecology, addictions;

2. Obstetrics;

3. Pediatrics;

4. Psychiatry;

5. Rehabilitation;

6. Chronic care;

7. Comprehensive care;

8. Extended care;

9. Intermediate care; or

10. Residential treatment; or

(ii) Any subcategory of the rehabilitation, psychiatry, comprehensive care, or intermediate care categories of health care services for which need is projected in the State health plan.

(b) The Commission may set an application fee for a certificate of need for HEALTH CARE facilities not assessed a user fee under [§ 19-122] § 19-111 of this subtitle.

(c) The Commission shall adopt rules and regulations for applying for and issuing certificates of need.

(d) [(1)] The Commission may adopt, after October 1, 1983, new thresholds or methods for determining the circumstances or minimum cost requirements under which a certificate of need application must be filed. [The Commission shall study alternative approaches and recommend alternatives that will streamline the current process, and provide incentives for management flexibility through the reduction of instances in which applicants must file for a certificate of need.

(2) The Commission shall conduct this study and report to the General Assembly by October 1, 1985.]

(e) (1) A person shall have a certificate of need issued by the Commission before the person develops, operates, or participates in any of the following health care projects for which a certificate of need is required under this section.

(2) A certificate of need issued prior to January 13, 1987 may not be rendered wholly or partially invalid solely because certain conditions have been imposed, if an appeal concerning the certificate of need, challenging the power of the Commission to impose certain conditions on a certificate of need, has not been noted by an aggrieved party before January 13, 1987.

(f) [A] EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A certificate of need is required before a new health care facility is built, developed, or established.

(g) (1) [A] EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A certificate of need is required before a health care facility is moved to another site.

(2) This subsection does not apply if:

(i) The Commission adopts limits for relocations and the proposed relocation does not exceed those limits; or

(ii) The relocation is the result of a partial or complete replacement of an existing hospital or related institution, as defined in § 19-301 of this title, and the relocation is to another part of the site or immediately adjacent to the site of the existing hospital or related institution.

(h) (1) [A] EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A certificate of need is required before the bed capacity of a health care facility is changed.

(2) This subsection does not apply to any increase or decrease in bed capacity if:

(i) During a 2-year period the increase or decrease would not exceed the lesser of 10 percent of the total bed capacity or 10 beds;

(ii) 1. The increase or decrease would change the bed capacity for an existing medical service; and

2. A. The change would not increase total bed capacity;

B. The change is maintained for at least a 1-year period; and

C. At least 45 days prior to the change the hospital provides written notice to the Commission describing the change and providing an updated inventory of the hospital's licensed bed complement; or

(iii) 1. At least 45 days before increasing or decreasing bed capacity, written notice of intent to change bed capacity is filed with the Commission; and

2. The Commission in its sole discretion finds that the proposed change:

A. Is pursuant to the consolidation or merger of 2 or more health care facilities, or conversion of a health care facility or part of a facility to a nonhealth-related use;

B. Is not inconsistent with the State health plan or the institution-specific plan developed by the Commission;

C. Will result in the delivery of more efficient and effective health care services; and

D. Is in the public interest.

(3) Within 45 days of receiving notice, the Commission shall notify the health care facility of its finding.

(i) (1) [A] EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A certificate of need is required before the type or scope of any health care service is changed if the health care service is offered:

(i) By a health care facility;

(ii) In space that is leased from a health care facility; or

(iii) In space that is on land leased from a health care facility.

(2) This subsection does not apply if:

(i) The Commission adopts limits for changes in health care services and the proposed change would not exceed those limits;

(ii) The proposed change and the annual operating revenue that would result from the addition is entirely associated with the use of medical equipment;

(iii) The proposed change would establish, increase, or decrease a health care service and the change would not result in the:

1. Establishment of a new medical service or elimination of an existing medical service;

2. Establishment of an open heart surgery, organ transplant surgery, or burn or neonatal intensive health care service;

3. Establishment of a [home health program, hospice program, or] freestanding ambulatory surgical center or facility; or

4. Expansion of a comprehensive care, extended care, intermediate care, residential treatment, psychiatry, or rehabilitation medical service, except for an expansion related to an increase in total bed capacity in accordance with subsection (h)(2)(i) of this section; or

(iv) 1. At least 45 days before increasing or decreasing the volume of 1 or more health care services, written notice of intent to change the volume of health care services is filed with the Commission;

2. The Commission in its sole discretion finds that the proposed change:

A. Is pursuant to the consolidation or merger of 2 or more health care facilities, or conversion of a health care facility or part of a facility to a nonhealth-related use;

B. Is not inconsistent with the State health plan or the institution-specific plan developed and adopted by the Commission;

C. Will result in the delivery of more efficient and effective health care services; and

D. Is in the public interest; and

3. Within 45 days of receiving notice under item 1 of this subparagraph, the Commission shall notify the health care facility of its finding.

[(3) Notwithstanding the provisions of paragraph (2) of this subsection, a certificate of need is required:

(i) Before an additional home health agency, branch office, or home health care service is established by an existing health care agency or facility;

(ii) Before an existing home health agency or health care facility establishes a home health agency or home health care service at a location in the service area not included under a previous certificate of need or license;

(iii) Before a transfer of ownership of any branch office of a home health agency or home health care service of an existing health care facility that separates the ownership of the branch office from the home health agency or home health care service of an existing health care facility which established the branch office; or

(iv) Before the expansion of a home health service or program by a health care facility that:

1. Established the home health service or program without a certificate of need between January 1, 1984 and July 1, 1984; and

2. During a 1-year period, the annual operating revenue of the home health service or program would be greater than $333,000 after an annual adjustment for inflation, based on an appropriate index specified by the Commission.]

(j) (1) [A] EXCEPT AS PROVIDED IN SUBSECTION (O) OF THIS SECTION, A certificate of need is required before any of the following capital expenditures are made by or on behalf of a health care facility:

(i) Any expenditure that, under generally accepted accounting principles, is not properly chargeable as an operating or maintenance expense, if:

1. The expenditure is made as part of an acquisition, improvement, or expansion, and, after adjustment for inflation as provided in the regulations of the Commission, the total expenditure, including the cost of each study, survey, design, plan, working drawing, specification, and other essential activity, is more than $1,250,000;

2. The expenditure is made as part of a replacement of any plant and equipment of the health care facility and is more than $1,250,000 after adjustment for inflation as provided in the regulations of the Commission;

3. The expenditure results in a substantial change in the bed capacity of the health care facility; or

4. The expenditure results in the establishment of a new medical service in a health care facility that would require a certificate of need under subsection (i) of this section; or

(ii) Any expenditure that is made to lease or, by comparable arrangement, obtain any plant or equipment for the health care facility, if:

1. The expenditure is made as part of an acquisition, improvement, or expansion, and, after adjustment for inflation as provided in the rules and regulations of the Commission, the total expenditure, including the cost of each study, survey, design, plan, working drawing, specification, and other essential activity, is more than $1,250,000;

2. The expenditure is made as part of a replacement of any plant and equipment and is more than $1,250,000 after adjustment for inflation as provided in the regulations of the Commission;

3. The expenditure results in a substantial change in the bed capacity of the health care facility; or

4. The expenditure results in the establishment of a new medical service in a health care facility that would require a certificate of need under subsection (i) of this section.

(2) A certificate of need is required before any equipment or plant is donated to a health care facility, if a certificate of need would be required under paragraph (1) of this subsection for an expenditure by the health care facility to acquire the equipment or plant directly.

(3) A certificate of need is required before any equipment or plant is transferred to a health care facility at less than fair market value if a certificate of need would be required under paragraph (1) of this subsection for the transfer at fair market value.

(4) A certificate of need is required before a person acquires a health care facility if a certificate of need would be required under paragraph (1) of this subsection for the acquisition by or on behalf of the health care facility.

(5) This subsection does not apply to:

(i) Site acquisition;

(ii) Acquisition of a health care facility if, at least 30 days before making the contractual arrangement to acquire the facility, written notice of the intent to make the arrangement is filed with the Commission and the Commission does not find, within 30 days after the Commission receives notice, that the health services or bed capacity of the facility will be changed;

(iii) Acquisition of business or office equipment that is not directly related to patient care;

(iv) Capital expenditures to the extent that they are directly related to the acquisition and installation of major medical equipment;

(v) A capital expenditure made as part of a consolidation or merger of 2 or more health care facilities, or conversion of a health care facility or part of a facility to a nonhealth-related use if:

1. At least 45 days before an expenditure is made, written notice of intent is filed with the Commission;

2. Within 45 days of receiving notice, the Commission in its sole discretion finds that the proposed consolidation, merger, or conversion:

A. Is not inconsistent with the State health plan or the institution-specific plan developed by the Commission as appropriate;

B. Will result in the delivery of more efficient and effective health care services; and

C. Is in the public interest; and

3. Within 45 days of receiving notice, the Commission shall notify the health care facility of its finding;

(vi) A capital expenditure by a nursing home for equipment, construction, or renovation that:

1. Is not directly related to patient care; and

2. Is not directly related to any change in patient charges or other rates;

(vii) A capital expenditure by a hospital, as defined in § 19-301 of this title, for equipment, construction, or renovation that:

1. Is not directly related to patient care; and

2. Does not increase patient charges or hospital rates;

(viii) A capital expenditure by a hospital as defined in § 19-301 of this title, for a project in excess of $1,250,000 for construction or renovation that:

1. May be related to patient care;

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

3. At least 45 days before the proposed expenditure is made, the hospital notifies the Commission and within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under item 2 of this subparagraph; and

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

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

1. At least 45 days before the proposed donation is made, the hospital notifies the Commission and within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under this subparagraph; and

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

(6) Paragraph (5)(vi), (vii), (viii), and (ix) of this subsection may not be construed to permit a facility to offer a new health care service for which a certificate of need is otherwise required.

(7) Subject to the notice requirements of paragraph (5)(ii) of this subsection, a hospital may acquire a freestanding ambulatory surgical facility or office of one or more health care practitioners or a group practice with one or more operating rooms used primarily for the purpose of providing ambulatory surgical services if the facility, office, or group practice:

(i) Has obtained a certificate of need;

(ii) Has obtained an exemption from certificate of need requirements; or

(iii) Did not require a certificate of need in order to provide ambulatory surgical services after June 1, 1995.

(8) Nothing in this subsection may be construed to permit a hospital to build or expand its ambulatory surgical capacity in any setting owned or controlled by the hospital without obtaining a certificate of need from the Commission if the building or expansion would increase the surgical capacity of the State's health care system.

(l) A certificate of need is not required to close any hospital or part of a hospital as defined in § 19-301 of this title if:

(1) At least 45 days before closing, written notice of intent to close is filed with the Commission;

(2) The Commission in its sole discretion finds that the proposed closing is not inconsistent with the State health plan or the institution-specific plan developed by the Commission and is in the public interest; and

(3) Within 45 days of receiving notice the Commission notifies the health care facility of its findings.

(m) In this section the terms "consolidation" and "merger" include increases and decreases in bed capacity or services among the components of an organization which:

(1) Operates more than one health care facility; or

(2) Operates one or more health care facilities and holds an outstanding certificate of need to construct a health care facility.

(n) (1) Notwithstanding any other provision of this section, the Commission shall consider the special needs and circumstances of a county where a medical service, as defined in this section, does not exist; and

(2) The Commission shall consider and may approve under this subsection a certificate of need application to establish, build, operate, or participate in a health care project to provide a new medical service in a county if the Commission, in its sole discretion, finds that:

(i) The proposed medical service does not exist in the county that the project would be located;

(ii) The proposed medical service is necessary to meet the health care needs of the residents of that county;

(iii) The proposed medical service would have a positive impact on the existing health care system;

(iv) The proposed medical service would result in the delivery of more efficient and effective health care services to the residents of that county; and

(v) The application meets any other standards or regulations established by the Commission to approve applications under this subsection.

(O) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, A CERTIFICATE OF NEED IS NOT REQUIRED FOR DEVELOPING, BUILDING, ESTABLISHING, OR OPERATING A HOME HEALTH AGENCY OR HOSPICE FACILITY OR FOR ANY HEALTH CARE SERVICE THAT A HOME HEALTH AGENCY OR HOSPICE FACILITY PROVIDES.

19-122.

(a) In this section, "health maintenance organization" means a health maintenance organization under Subtitle 7 of this title.

(b) (1) A health maintenance organization or a health care facility that either controls, directly or indirectly, or is controlled by a health maintenance organization shall have a certificate of need before the health maintenance organization or health care facility builds, develops, operates, purchases, or participates in building, developing, operating, or establishing:

(i) A hospital, as defined in § 19-301 of this title, or an ambulatory surgical facility or center, as defined in [§ 19-101(f)] § 19-112(E) of this subtitle; and

(ii) Any other health care project for which a certificate of need is required under [§ 19-115] § 19-121 of this subtitle if that health care project is planned for or used by any nonsubscribers of that health maintenance organization.

(2) Notwithstanding paragraph (1)(i) of this subsection, a health maintenance organization or a health care facility that either controls, directly or indirectly, or is controlled by a health maintenance organization is not required to obtain a certificate of need before purchasing an existing ambulatory surgical facility or center, as defined in [§ 19-101(f) of this title] § 19-112(E) OF THIS SUBTITLE.

(c) An application for a certificate of need by a health maintenance organization or by a health care facility that either controls, directly or indirectly, or is controlled by, a health maintenance organization shall be approved if the Commission finds that the application:

(1) Documents that the project is necessary to meet the needs of enrolled members and reasonably anticipated new members for the services proposed to be provided by the applicant; and

(2) Is not inconsistent with those sections of the State health plan or those sections of the institution-specific plan that govern hospitals, as defined in § 19-301 of this title, and ambulatory surgical facilities or centers, as defined in [§ 19-101(f)] § 19-112(E) of this subtitle, or health care projects for which a certificate of need is required under subsection (b)(1)(ii) of this section.

19-123.

A certificate of need is not required to delete, expand, develop, operate, or participate in a health care project for domiciliary care.

19-124.

A certificate of need is required before an ambulatory care facility:

(1) Offers any health service:

(i) Through a health care facility;

(ii) In space leased from a health care facility; or

(iii) In space on land leased from a health care facility;

(2) To provide those services, makes an expenditure, if a certificate of need would be required under [§ 19-115(j)] § 19-121(J) of this subtitle for the expenditure by or on behalf of a health care facility;

(3) Acquires medical equipment if a certificate of need would be required under [§ 19-115(k)] § 19-121(K) of this subtitle for the acquisition by a health care facility; or

(4) Does anything else for which the Federal Act requires a certificate of need and that the Commission has not exempted from that requirement.

19-125.

(a) If the Commission receives an application for a certificate of need for a change in the bed capacity of a health care facility, as required under [§ 19-115] § 19-121 of this subtitle, or for a health care project that would create a new health care service or abolish an existing health care service, the Commission shall give notice of the filing by publication in the Maryland Register and give the following notice to:

(1) Each member of the General Assembly in whose district the action is planned;

(2) Each member of the governing body for the county where the action is planned;

(3) The county executive, mayor, or chief executive officer, if any, in whose county or city the action is planned; and

(4) Any health care provider, third party payor, local planning agency, or any other person the Commission knows has an interest in the application.

(b) Failure to give notice shall not adversely affect the application.

(c) (1) All decisions of the Commission on an application for a certificate of need, except in emergency circumstances posing a threat to public health, shall be consistent with the State health plan and the standards for review established by the Commission.

(2) The mere failure of the State health plan to address any particular project or health care service shall not alone be deemed to render the project inconsistent with the State health plan.

(3) Unless the Commission finds that the facility or service for which the proposed expenditure is to be made is not needed or is not consistent with the State health plan, the Commission shall approve an application for a certificate of need required under [§ 19-115(j)] § 19-121(J) of this subtitle to the extent that the expenditure is to be made to:

(i) Eliminate or prevent an imminent safety hazard, as defined by federal, State, or local fire, building, or life safety codes or regulations;

(ii) Comply with State licensing standards; or

(iii) Comply with accreditation standards for reimbursement under Title XVIII of the Social Security Act or under the State Medical Assistance Program approved under Title XIX of the Social Security Act.

(d) (1) The Commission alone shall have final nondelegable authority to act upon an application for a certificate of need, except as provided in this subsection.

[(1)] (2) [Seven] FIVE voting members of the Commission shall be a quorum TO ACT ON AN APPLICATION FOR A CERTIFICATE OF NEED.

[(2)] (3) After an application is filed, the staff of the Commission:

(i) Shall review the application for completeness within 10 working days of the filing of the application; and

(ii) May request further information from the applicant.

[(3)] (4) The Commission may delegate to a reviewer the responsibility for review of an application for a certificate of need, including:

(i) The holding of an evidentiary hearing if the Commission, in accordance with criteria it has adopted by regulation, considers an evidentiary hearing appropriate due to the magnitude of the impact the proposed project may have on the health care delivery system; and

(ii) Preparation of a recommended decision for consideration by the full Commission.

[(4)] (5) The Commission shall designate a single Commissioner to act as a reviewer for the application and any competing applications.

[(5)] (6) The Commission shall delegate to its staff the responsibility for an initial review of an application, including, in the event that no written comments on an application are submitted by any interested party other than the staff of the Commission, the preparation of a recommended decision for consideration by the full Commission.

[(6)] (7) Any "interested party" may submit written comments on the application in accordance with procedural regulations adopted by the Commission.

[(7)] (8) The Commission shall define the term "interested party" to include, at a minimum:

(i) The staff of the Commission;

(ii) Any applicant who has submitted a competing application; and

(iii) Any other person who can demonstrate that the person would be adversely affected by the decision of the Commission on the application.

[(8)] (9) The reviewer shall review the application, any written comments on the application, and any other materials permitted by this section or by the Commission's regulations, and present a recommended decision on the application to the full Commission.

[(9)] (10) (i) An applicant and any interested party may request the opportunity to present oral argument to the reviewer, in accordance with regulations adopted by the Commission, before the reviewer prepares a recommended decision on the application for consideration by the full Commission.

(ii) The reviewer may grant, deny, or impose limitations on an interested party's request to present oral argument to the reviewer.

[(10)] (11) Any interested party who has submitted written comments under paragraph [(6)] (7) of this subsection may submit written exceptions to the proposed decision and make oral argument to the Commission, in accordance with regulations adopted by the Commission, before the Commission takes final action on the application.

[(11)] (12) The Commission shall, after determining that the recommended decision is complete, vote to approve, approve with conditions, or deny the application on the basis of the recommended decision, the record before the staff or the reviewer, and exceptions and arguments, if any, before the Commission.

[(12)] (13) The decision of the Commission shall be by a majority of the quorum present and voting, except that no project shall be approved without the affirmative vote of at least two consumer members of the Commission.

(e) Where the State health plan identifies a need for additional hospital bed capacity in a region or subregion, in a comparative review of 2 or more applicants for

hospital bed expansion projects, a certificate of need shall be granted to 1 or more applicants in that region or subregion that:

(1) Have satisfactorily met all applicable standards;

(2) (i) Have within the preceding 10 years voluntarily delicensed the greater of 10 beds or 10 percent of total licensed bed capacity to the extent of the beds that are voluntarily delicensed; or

(ii) Have been previously granted a certificate of need which was not recertified by the Commission within the preceding 10 years; and

(3) The Commission finds at least comparable to all other applicants.

(f) (1) If any party or interested person requests an evidentiary hearing with respect to a certificate of need application for any health care facility other than an ambulatory surgical facility and the Commission, in accordance with criteria it has adopted by regulation, considers an evidentiary hearing appropriate due to the magnitude of the impact that the proposed project may have on the health care delivery system, the Commission or a committee of the Commission shall hold the hearing in accordance with the contested case procedures of the Administrative Procedure Act.

(2) Except as provided in this section or in regulations adopted by the Commission to implement the provisions of this section, the review of an application for a certificate of need for an ambulatory surgical facility is not subject to the contested case procedures of Title 10, Subtitle 2 of the State Government Article.

(g) (1) An application for a certificate of need shall be acted upon by the Commission no later than 150 days after the application was docketed.

(2) If an evidentiary hearing is not requested, the Commission's decision on an application shall be made no later than 90 days after the application was docketed.

(h) (1) The applicant or any aggrieved party, as defined in [§ 19-120(a)] § 19-127(A) of this subtitle, may petition the Commission within 15 days for a reconsideration.

(2) The Commission shall decide whether or not it will reconsider its decision within 30 days of receipt of the petition for reconsideration.

(3) The Commission shall issue its reconsideration decision within 30 days of its decision on the petition.

(i) If the Commission does not act on an application within the required period, the applicant may file with a court of competent jurisdiction within 60 days after expiration of the period a petition to require the Commission to act on the application.

19-126.

The circuit court for the county where a health care project is being developed or operated in violation of [Part I] THIS PART II of this subtitle may enjoin further development or operation.

19-127.

(a) (1) In this section, "aggrieved party" means:

(i) An interested party who presented written comments on the application to the Commission and who would be adversely affected by the decision of the Commission on the project; or

(ii) The Secretary.

(2) The grounds for appeal by the Secretary shall be that the decision is inconsistent with the State health plan or adopted standards.

(b) (1) A decision of the Commission shall be the final decision for purposes of judicial review.

(2) A request for a reconsideration will stay the final decision of the Commission for purposes of judicial review until a decision is made on the reconsideration.

(C) AN AGGRIEVED PARTY MAY NOT APPEAL A FINAL DECISION OF THE COMMISSION TO THE BOARD OF REVIEW BUT MAY TAKE A DIRECT JUDICIAL APPEAL WITHIN 30 DAYS OF THE FINAL DECISION OF THE COMMISSION.

[(c)] (D) The Commission is a necessary party to an appeal at all levels of the appeal.

[(d)] (E) In the event of an adverse decision that affects its final decision, the Commission may apply within 30 days by writ of certiorari to the Court of Appeals for review where:

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

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

19-128.

(a) Notwithstanding the fact that a merger or consolidation may limit free economic competition, the Commission may approve the merger or consolidation of 2 or more hospitals if the merger or consolidation:

(1) Is not inconsistent with the State health plan or any institution-specific plan;

(2) Will result in the delivery of more efficient and effective hospital services; and

(3) Is in the public interest.

(b) Notwithstanding the fact that a merger or consolidation or the joint ownership and operation of major medical equipment may limit free economic competition, a hospital may engage in a merger or consolidation or the joint ownership of major medical equipment that has been approved by the Commission under this section.

PART III. HEALTH CARE FACILITY RATE SETTING.

19-129.

(a) In this [subtitle] PART III OF THIS SUBTITLE the following words have the meanings indicated.

(b) ["Commission" means the State Health Services Cost Review Commission.

(c)] "Facility" means, whether operated for a profit or not:

(1) Any hospital; or

(2) Any related institution.

[(d)] (C) (1) "Hospital services" means:

(i) Inpatient hospital services as enumerated in Medicare Regulation 42 C.F.R. § 409.10, as amended;

(ii) Emergency services;

(iii) Outpatient services provided at the hospital; and

(iv) Identified physician services for which a facility has Commission-approved rates on June 30, 1985.

(2) "Hospital services" does not include outpatient renal dialysis services.

[(e)] (D) (1) "Related institution" means an institution that is licensed by the Department as:

(i) A comprehensive care facility that is currently regulated by the Commission; or

(ii) An intermediate care facility - mental retardation.

(2) "Related institution" includes any institution in paragraph (1) of this subsection, as reclassified from time to time by law.

19-130.

(A) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS SUBTITLE, IN THIS PART III OF THIS SUBTITLE THE COMMISSION SHALL:

(1) WITHIN A REASONABLE TIME AFTER THE END OF EACH FACILITY'S FISCAL YEAR OR MORE OFTEN AS THE COMMISSION DETERMINES, PREPARE FROM THE INFORMATION FILED WITH THE COMMISSION ANY SUMMARY, COMPILATION, OR OTHER SUPPLEMENTARY REPORT THAT WILL ADVANCE THE PURPOSES OF THIS PART; AND

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

(I) HEALTH CARE COSTS;

(II) THE FINANCIAL STATUS OF ANY FACILITY; OR

(III) ANY OTHER APPROPRIATE MATTER.

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

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

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

19-131.

(a) (1) Except for a facility that is operated or is listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts, the Commission has jurisdiction over hospital services offered by or through all facilities.

(2) The jurisdiction of the Commission over any identified physician service shall terminate for a facility on the request of the facility.

(3) The rate approved for an identified physician service may not exceed the rate on June 30, 1985, adjusted by an appropriate index of inflation.

(b) The Commission may not set rates for related institutions until:

(1) State law authorizes the State Medical Assistance Program to reimburse related institutions at Commission rates; and

(2) The United States Department of Health and Human Services agrees to accept Commission rates as a method of providing federal financial participation in the State Medical Assistance Program.

19-132.

The Commission shall:

(1) Require each facility to disclose publicly:

(i) Its financial position; and

(ii) As computed by methods that the Commission determines, the verified total costs incurred by the facility in providing health services;

(2) Review for reasonableness and certify the rates of each facility;

(3) Keep informed as to whether a facility has enough resources to meet its financial requirements;

(4) Concern itself with solutions if a facility does not have enough resources; and

(5) Assure each purchaser of health care facility services that:

(i) The total costs of all hospital services offered by or through a facility are reasonable;

(ii) The aggregate rates of the facility are related reasonably to the aggregate costs of the facility; and

(iii) Rates are set equitably among all purchasers of services without undue discrimination.

19-133.

(a) The Commission shall assess the underlying causes of hospital uncompensated care and make recommendations to the General Assembly on the most appropriate alternatives to:

(1) Reduce uncompensated care; and

(2) Assure the integrity of the payment system.

(b) The Commission may adopt regulations establishing alternative methods for financing the reasonable total costs of hospital uncompensated care provided that the alternative methods:

(1) Are in the public interest;

(2) Will equitably distribute the reasonable costs of uncompensated care;

(3) Will fairly determine the cost of reasonable uncompensated care included in hospital rates;

(4) Will continue incentives for hospitals to adopt efficient and effective credit and collection policies; and

(5) Will not result in significantly increasing costs to Medicare or the loss of Maryland's Medicare Waiver under Section 1814(b) of the Social Security Act.

(c) Any funds generated through hospital rates under an alternative method adopted by the Commission in accordance with subsection (b) of this section may only be used to finance the delivery of hospital uncompensated care.

19-134.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) (I) "AMBULATORY SURGICAL FACILITY" MEANS ANY CENTER, SERVICE, OFFICE FACILITY, OR OTHER ENTITY THAT:

1. OPERATES PRIMARILY FOR THE PURPOSE OF PROVIDING SURGICAL SERVICES TO PATIENTS REQUIRING A PERIOD OF POSTOPERATIVE OBSERVATION BUT NOT REQUIRING OVERNIGHT HOSPITALIZATION; AND

2. SEEKS REIMBURSEMENT FROM PAYORS AS AN AMBULATORY SURGERY CENTER.

(II) "AMBULATORY SURGICAL FACILITY" DOES NOT INCLUDE:

1. THE OFFICE OF ONE OR MORE HEALTH CARE PRACTITIONERS SEEKING ONLY PROFESSIONAL REIMBURSEMENT FOR THE PROVISIONS OF MEDICAL SERVICES, UNLESS:

A. THE OFFICE OPERATES UNDER CONTRACT OR OTHER AGREEMENT WITH A PAYOR AS AN AMBULATORY SURGICAL FACILITY REGARDLESS OF WHETHER IT IS PAID A TECHNICAL OR FACILITY FEE; OR

B. THE OFFICE IS DESIGNATED TO RECEIVE AMBULATORY SURGICAL REFERRALS IN ACCORDANCE WITH UTILIZATION REVIEW OR OTHER POLICIES ADOPTED BY A PAYOR;

2. ANY FACILITY OR SERVICE OWNED OR OPERATED BY A HOSPITAL AND REGULATED UNDER THIS PART III OF THIS SUBTITLE;

3. THE OFFICE OF A HEALTH CARE PRACTITIONER WITH NOT MORE THAN ONE OPERATING ROOM IF:

A. THE OFFICE DOES NOT RECEIVE A TECHNICAL OR FACILITY FEE; AND

B. THE OPERATING ROOM IS USED EXCLUSIVELY BY THE HEALTH CARE PRACTITIONER FOR PATIENTS OF THE HEALTH CARE PRACTITIONER;

4. THE OFFICE OF A GROUP OF HEALTH CARE PRACTITIONERS WITH NOT MORE THAN ONE OPERATING ROOM IF:

A. THE OFFICE DOES NOT RECEIVE A TECHNICAL OR FACILITY FEE; AND

B. THE OPERATING ROOM IS USED EXCLUSIVELY BY MEMBERS OF THE GROUP PRACTICE FOR PATIENTS OF THE GROUP PRACTICE; OR

5. AN OFFICE OWNED OR OPERATED BY ONE OR MORE DENTISTS LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE.

(3) "FREESTANDING AMBULATORY CARE FACILITY" MEANS:

(I) AN AMBULATORY SURGICAL FACILITY;

(II) A FREESTANDING ENDOSCOPY FACILITY;

(III) A FREESTANDING FACILITY UTILIZING MAJOR MEDICAL EQUIPMENT;

(IV) A KIDNEY DIALYSIS CENTER; OR

(V) A FREESTANDING BIRTHING CENTER.

(4) (I) "FREESTANDING BIRTHING CENTER" MEANS A FACILITY THAT PROVIDES NURSE MIDWIFE SERVICES UNDER TITLE 8, SUBTITLE 6 OF THE HEALTH OCCUPATIONS ARTICLE.

(II) "FREESTANDING BIRTHING CENTER" DOES NOT INCLUDE:

1. A HOSPITAL REGULATED UNDER THIS PART III OF THIS SUBTITLE; OR

2. THE PRIVATE RESIDENCE OF THE MOTHER.

(5) (I) "FREESTANDING ENDOSCOPY FACILITY" MEANS A FACILITY:

1. FOR THE TESTING, DIAGNOSIS, OR TREATMENT OF A MEDICAL DISORDER IN CONJUNCTION WITH THE USE OF MICROSCOPIC, ENDOSCOPIC, OR LAPAROSCOPIC EQUIPMENT THAT IS INSERTED IN A NATURALLY OCCURRING ORIFICE OF THE BODY; AND

2. THAT SEEKS REIMBURSEMENT AS A FREESTANDING ENDOSCOPY FACILITY FROM PAYORS OR MEDICARE.

(II) "FREESTANDING ENDOSCOPY FACILITY" DOES NOT INCLUDE:

1. THE OFFICE OF ONE OR MORE HEALTH CARE PRACTITIONERS UNLESS:

A. THE OFFICE OPERATES UNDER A CONTRACT OR OTHER AGREEMENT WITH A PAYOR AS A FREESTANDING ENDOSCOPY FACILITY REGARDLESS OF WHETHER IT IS PAID A TECHNICAL OR FACILITY FEE; OR

B. THE OFFICE IS DESIGNATED TO RECEIVE ENDOSCOPIC REFERRALS IN ACCORDANCE WITH UTILIZATION REVIEW OR OTHER POLICIES ADOPTED BY A PAYOR; OR

2. ANY FACILITY OR SERVICE OPERATED BY A HOSPITAL AND REGULATED UNDER THIS PART III OF THIS SUBTITLE.

(6) (I) "FREESTANDING FACILITY OPERATING MAJOR MEDICAL EQUIPMENT" MEANS A FACILITY USING MAJOR MEDICAL EQUIPMENT.

(II) "FREESTANDING FACILITY OPERATING MAJOR MEDICAL EQUIPMENT" DOES NOT INCLUDE ANY FACILITY OR SERVICE OWNED OR OPERATED BY A HOSPITAL AND REGULATED UNDER THIS PART.

(7) "GROUP PRACTICE" MEANS A GROUP OF TWO OR MORE HEALTH CARE PRACTITIONERS LEGALLY ORGANIZED AS A PARTNERSHIP, PROFESSIONAL CORPORATION, FOUNDATION, NONPROFIT CORPORATION, FACULTY PRACTICE PLAN, OR SIMILAR ASSOCIATION:

(I) IN WHICH EACH HEALTH CARE PRACTITIONER WHO IS A MEMBER OF THE GROUP PROVIDES SUBSTANTIALLY THE FULL RANGE OF SERVICES THAT THE PRACTITIONER ROUTINELY PROVIDES THROUGH THE JOINT USE OF SHARED OFFICE SPACE, FACILITIES, EQUIPMENT, AND PERSONNEL;

(II) FOR WHICH SUBSTANTIALLY ALL OF THE SERVICES OF THE HEALTH CARE PRACTITIONERS WHO ARE MEMBERS OF THE GROUP ARE:

1. PROVIDED THROUGH THE GROUP; AND

2. BILLED IN THE NAME OF THE GROUP AND ANY AMOUNTS RECEIVED ARE TREATED AS RECEIPTS OF THE GROUP; AND

(III) IN WHICH THE OVERHEAD EXPENSES OF AND THE INCOME FROM THE GROUP ARE DISTRIBUTED IN ACCORDANCE WITH METHODS PREVIOUSLY DETERMINED ON AN ANNUAL BASIS BY MEMBERS OF THE GROUP.

(8) "HEALTH CARE PRACTITIONER" MEANS A PERSON WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE MEDICAL SERVICES, INCLUDING SURGICAL SERVICES, IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION.

(9) (I) "KIDNEY DIALYSIS CENTER" MEANS A FACILITY THAT PROVIDES HEMODIALYSIS OR CHRONIC PERITONEAL DIALYSIS.

(II) "KIDNEY DIALYSIS CENTER" DOES NOT INCLUDE ANY FACILITY OR SERVICE OWNED OR OPERATED BY A HOSPITAL AND REGULATED UNDER THIS PART III OF THIS SUBTITLE.

(10) "MAJOR MEDICAL EQUIPMENT" MEANS:

(I) CARDIAC CATHETERIZATION EQUIPMENT;

(II) A COMPUTER TOMOGRAPHY (CT) SCANNER;

(III) A LITHOTRIPTER;

(IV) RADIATION THERAPY EQUIPMENT, INCLUDING A LINEAR ACCELERATOR; OR

(V) A MAGNETIC RESONANCE IMAGER (MRI).

(11) "PAYOR" MEANS:

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

(II) A THIRD PARTY ADMINISTRATOR OR ANY OTHER ENTITY UNDER CONTRACT WITH A MARYLAND BUSINESS TO ADMINISTER A HEALTH BENEFIT PLAN; OR

(III) A SELF-INSURED GROUP.

(12) "SURGICAL SERVICES" MEANS ANY INVASIVE PROCEDURE WHETHER THERAPEUTIC OR DIAGNOSTIC INVOLVING THE USE OF:

(I) ANY CUTTING INSTRUMENT;

(II) MICROSCOPIC, ENDOSCOPIC, ARTHROSCOPIC, OR LAPAROSCOPIC EQUIPMENT; OR

(III) A LASER FOR THE REMOVAL OR REPAIR OF AN ORGAN OR OTHER TISSUE.

(B) THE COMMISSION MAY ADOPT REGULATIONS ESTABLISHING A METHOD AND MECHANISM TO FINANCE THE REASONABLE TOTAL COST OF UNCOMPENSATED CARE FOR THE TYPES OF PROCEDURES AND SERVICES PERFORMED OR PROVIDED BY FREESTANDING AMBULATORY CARE FACILITIES, PROVIDED THAT THE METHOD AND MECHANISM:

(1) IS CONSISTENT WITH THE METHOD ADOPTED BY THE COMMISSION UNDER § 19-133 OF THIS SUBTITLE;

(2) IS IN THE PUBLIC INTEREST;

(3) WILL CONTINUE TO EQUITABLY DISTRIBUTE THE REASONABLE COSTS OF UNCOMPENSATED CARE;

(4) WILL FAIRLY DETERMINE THE COSTS OF REASONABLE UNCOMPENSATED CARE INCLUDED IN THE CHARGES FOR PROCEDURES OR SERVICES PERFORMED OR PROVIDED BY FREESTANDING AMBULATORY CARE FACILITIES; AND

(5) WILL PROVIDE INCENTIVES FOR FREESTANDING AMBULATORY CARE FACILITIES TO ADOPT EFFICIENT AND EFFECTIVE CREDIT AND COLLECTION POLICIES.

(C) (1) THE METHOD AND MECHANISM ADOPTED BY REGULATION BY THE COMMISSION UNDER SUBSECTION (B) OF THIS SECTION SHALL INCLUDE AN ASSESSMENT FOR REASONABLE UNCOMPENSATED CARE ON EACH FREESTANDING AMBULATORY CARE FACILITY FOR EACH PROCEDURE AND SERVICE PERFORMED OR PROVIDED BY THE FACILITY THAT IS EQUAL TO THE AVERAGE DOLLAR AMOUNT INCLUDED IN HOSPITAL OUTPATIENT RATES FOR UNCOMPENSATED CARE FOR A COMPARABLE CATEGORY OF PROCEDURE OR SERVICE.

(2) THE ASSESSMENT CHARGED TO EACH AMBULATORY SURGICAL FACILITY SHALL BE OFFSET BY THE ACTUAL DOCUMENTED REASONABLE UNCOMPENSATED CARE PROVIDED BY THE FACILITY.

(D) THE FUNDS GENERATED THROUGH THE METHOD AND MECHANISM ADOPTED BY REGULATION BY THE COMMISSION UNDER SUBSECTION (B) OF THIS SECTION MAY BE USED ONLY TO FINANCE THE DELIVERY OF REASONABLE UNCOMPENSATED CARE FOR THE TYPES OF PROCEDURES AND SERVICES PERFORMED OR PROVIDED IN HOSPITAL-BASED AND FREE-STANDING AMBULATORY CARE FACILITIES.

19-135.

(a) (1) After public hearings and consultation with any appropriate advisory committee, the Commission shall adopt, by [rule or] regulation, a uniform accounting and financial reporting system that:

(i) Includes any cost allocation method that the Commission determines; and

(ii) Requires each facility to record its income, revenues, assets, expenses, outlays, liabilities, and units of service.

(2) Each facility shall adopt the uniform accounting and financial reporting system.

(b) In conformity with this [subtitle] PART III OF THIS SUBTITLE, the Commission may allow and provide for modifications in the uniform accounting and financial reporting system to reflect correctly any differences among facilities in their type, size, financial structure, or scope or type of service.

19-136.

(a) At the end of the fiscal year for a facility at least 120 days following a merger or a consolidation and at any other interval that the Commission sets, the facility shall file:

(1) A balance sheet that details its assets, liabilities, and net worth;

(2) A statement of income and expenses; and

(3) Any other report that the Commission requires about costs incurred in providing services.

(b) (1) A report under this section shall:

(i) Be in the form that the Commission requires;

(ii) Conform to the uniform accounting and financial reporting system adopted under § 19-135 OF this subtitle; and

(iii) Be certified as follows:

1. For the University of Maryland Hospital, by the Legislative Auditor; or

2. For any other facility, by its certified public accountant.

(2) If the Commission requires, responsible officials of a facility also shall attest that, to the best of their knowledge and belief, the report has been prepared in conformity with the uniform accounting and financial reporting system adopted under § 19-135 OF this subtitle.

19-137.

(a) Except as provided in subsection (c) of this section, a facility shall notify the Commission at least 30 days prior to executing any financial transaction, contract, or other agreement that would:

(1) Pledge more than 50% of the operating assets of the facility as collateral for a loan or other obligation; or

(2) Result in more than 50% of the operating assets of the facility being sold, leased, or transferred to another person or entity.

(b) Except as provided in subsection (c) of this section, the Commission shall publish a notice of the proposed financial transaction, contract, or other agreement reported by a facility in accordance with subsection (a) of this section in a newspaper of general circulation in the area where the facility is located.

(c) The provisions of this section do not apply to any financial transaction, contract, or other agreement made by a facility with any issuer of tax exempt bonds,

including the Maryland Health and Higher Education Facilities Authority, the State, or any county or municipal corporation of the State, if a notice of the proposed issuance of revenue bonds that meets the requirements of § 147(f) of the Internal Revenue Code has been published.

19-138.

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

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

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

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

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

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

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

[(ii)] (2) The Medical and Chirurgical Faculty of the State of Maryland; or

[(iii)] (3) The State Board of Physician Quality Assurance.

19-139.

(a) The Commission may review costs and rates and make any investigation that the Commission considers necessary to assure each purchaser of health care facility services that:

(1) The total costs of all hospital services offered by or through a facility are reasonable;

(2) The aggregate rates of the facility are related reasonably to the aggregate costs of the facility; and

(3) The rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

(b) (1) To carry out its powers under subsection (a) of this section, the Commission may review and approve or disapprove the reasonableness of any rate that a facility sets or requests.

(2) A facility shall charge for services only at a rate set in accordance with this [subtitle] PART III OF THIS SUBTITLE.

(3) In determining the reasonableness of rates, the Commission may take into account objective standards of efficiency and effectiveness.

(c) To promote the most efficient and effective use of health care facility services and, if it is in the public interest and consistent with this [subtitle] THIS PART III OF THIS SUBTITLE, the Commission may promote and approve alternate methods of rate determination and payment that are of an experimental nature.

19-140.

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

(2) The information shall include:

(i) Necessary operating expenses;

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

(iii) Incurred interest charges; and

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

(b) (1) The Commission shall define, by [rule or] regulation, the types and classes of charges that may not be changed, except as specified in [§ 19-219] § 19-142 of this subtitle.

(2) (I) THE COMMISSION SHALL DEFINE BY REGULATION THE TYPES AND CLASSES OF HOSPITAL OUTPATIENT SERVICES FOR WHICH HOSPITALS MAY CHARGE BELOW COMMISSION-APPROVED RATES IF:

1. THE COMMISSION CONTINUES TO SET THE MAXIMUM ALLOWABLE RATES FOR THESE HOSPITAL OUTPATIENT SERVICES; AND

2. THE REVENUE LOSSES, IF ANY, ASSOCIATED WITH REDUCTIONS IN COMMISSION-APPROVED RATES FOR THESE HOSPITAL OUTPATIENT SERVICES ARE NOT RECOGNIZED BY THE COMMISSION AS REASONABLE COSTS FOR REIMBURSEMENT AND ARE NOT USED TO JUSTIFY A RATE INCREASE.

(II) IN DEFINING THE TYPES AND CLASSES OF HOSPITAL OUTPATIENT SERVICES FOR WHICH HOSPITALS MAY CHARGE BELOW COMMISSION-APPROVED RATES UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE COMMISSION MAY ESTABLISH MINIMUM ALLOWABLE RATES FOR THESE HOSPITAL OUTPATIENT SERVICES.

(III) FOR ANY MINIMUM ALLOWABLE RATES ESTABLISHED UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE COMMISSION SHALL INCLUDE IN THE RATES AN ASSESSMENT FOR REASONABLE UNCOMPENSATED CARE FOR EACH OUTPATIENT PROCEDURE AND SERVICE PERFORMED OR PROVIDED BY THE HOSPITAL FOR WHICH THE HOSPITAL CHARGES BELOW COMMISSION-APPROVED RATES THAT ARE EQUAL TO THE AVERAGE DOLLAR AMOUNT INCLUDED IN THE HOSPITAL'S STANDARD COMMISSION-APPROVED RATE FOR UNCOMPENSATED CARE FOR THE SAME OUTPATIENT PROCEDURE OR SERVICE.

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

(d) The Commission shall:

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

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

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

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

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

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

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

19-141.

The Commission shall use any reasonable, relevant, or generally accepted accounting principles to determine reasonable rates for each facility.

19-142.

(a) (1) A facility may not change any rate schedule or charge of any type or class defined under [§ 19-217(b)] § 19-140(B) of this subtitle, unless the facility files with the Commission a written notice of the proposed change that is supported by any information that the facility considers appropriate.

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

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

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

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

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

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

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

(5) The Commission:

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

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

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

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

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

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

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

(2) Accept any benefits under that decision.

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

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

(i) Funds received because of the change; and

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

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

(i) To refund the funds with interest; or

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

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

(g) (1) The [State Health Services Cost Review] Commission shall provide incentives for merger, consolidation, and conversion and for the implementation of the institution-specific plan [developed by the Health Resources Planning Commission] THAT IT DEVELOPS UNDER PART II OF THIS SUBTITLE.

(2) Notwithstanding any of the provisions in this section, on notification of a merger or consolidation by 2 or more hospitals, the Commission shall review the rates of those hospitals that are directly involved in the merger or consolidation in accordance with the rate review and approval procedures provided in [§ 19-217] § 19-140 of this subtitle and the regulations of the Commission.

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

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

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

(iii) Any other closure costs as defined in § 16A of Article 43C of the Code; or

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

19-143.

The Commission shall assess a fee on all hospitals whose rates have been approved by the Commission to pay for:

(1) The amounts required by subsection (j) of § 16A of Article 43C of the Code with respect to public body obligations or closure costs of a closed or delicensed hospital as defined in Article 43C, § 16A of the Code; and

(2) Funding the Hospital Employees Retraining Fund.

19-144.

(a) This section applies to each person [who] THAT is concurrently:

(1) A trustee, director, or officer of any nonprofit facility in this State; and

(2) An employee, partner, director, officer, or beneficial owner of 3 percent or more of the capital account or stock of:

(i) A partnership;

(ii) A firm;

(iii) A corporation; or

(iv) Any other business entity.

(b) Each person specified in subsection (a) of this section shall file with the Commission an annual report that discloses, in detail, each business transaction between any business entity specified in subsection (a)(2) of this section and any facility that the person serves as specified in subsection (a)(1) of this section, if any of the following is $10,000 or more a year:

(1) The actual or imputed value or worth to the business entity of any transaction between it and the facility.

(2) The amount of the contract price, consideration, or other advances by the facility as part of the transaction.

(c) A report under this section shall be:

(1) Signed and verified; and

(2) Filed in accordance with the procedures and on the form that the Commission requires.

(d) A person [who] THAT willfully fails to file any report required by this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500.

19-145.

(a) In any matter that relates to the cost of services in facilities, the Commission may:

(1) Hold a public hearing;

(2) Conduct an investigation;

(3) Require the filing of any information; or

(4) Subpoena any witness or evidence.

(b) The Executive Director of the Commission may administer oaths in connection with any hearing or investigation under this section.

19-146.

(a) If the Commission considers a further investigation necessary or desirable to authenticate information in a report that a facility files under this [subtitle] PART III OF THIS SUBTITLE, the Commission may make any necessary further examination of the records or accounts of the facility, in accordance with the rules or regulations of the Commission.

(b) The examination under this section may include a full or partial audit of the records or accounts of the facility that is:

(1) Provided by the facility; or

(2) Performed by:

(i) The staff of the Commission;

(ii) A third party for the Commission; or

(iii) The Legislative Auditor.

19-147.

(a) (1) Any person aggrieved by a final decision of the Commission under this PART III OF THIS subtitle may not appeal to the Board of Review but may take a direct judicial appeal.

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

(b) (1) An appeal from a final decision of the Commission under this section shall be taken in the name of the person aggrieved as appellant and against the Commission as appellee.

(2) The Commission is a necessary party to an appeal at all levels of the appeal.

(3) The Commission may appeal any decision that affects any of its final decisions to a higher level for further review.

(4) On grant of leave by the appropriate court, any aggrieved party or interested person may intervene or participate in an appeal at any level.

(c) Any person, government agency, or nonprofit health service plan that contracts with or pays a facility for health care services has standing to participate in Commission hearings and shall be allowed to appeal final decisions of the Commission.

PART IV. MEDICAL CARE DATA COLLECTION.

19-148.

(a) In this [subtitle] PART IV OF THIS SUBTITLE the following words have the meanings indicated.

(b) ["Commission" means the Maryland Health Care Access and Cost Commission.

(c) "Comprehensive standard health benefit plan" means the comprehensive standard health benefit plan adopted in accordance with § 15-1207 of the Insurance Article.

(d)] (1) "Health care provider" means:

(i) A person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care in the ordinary course of business or practice of a profession or in an approved education or training program; or

(ii) A facility where health care is provided to patients or recipients, including:

1. [a] A facility, as defined in § 10-101(e) of this article[,];

2. [a] A hospital, as defined in § 19-301(f) of this article[,];

3. [a] A related institution, as defined in § 19-301(n) of this article[,];

4. [a] A health maintenance organization, as defined in § 19-701(e) of this article[,];

5. [an] An outpatient clinic[,]; and

6. [a] A medical laboratory.

(2) "Health care provider" includes the agents and employees of a facility who are licensed or otherwise authorized to provide health care, the officers and directors of a facility, and the agents and employees of a health care provider who are licensed or otherwise authorized to provide health care.

[(e)] (C) "Health care practitioner" means any person that provides health care services and is licensed under the Health Occupations Article.

[(f)] (D) "Health care service" means any health or medical care procedure or service rendered by a health care practitioner that:

(1) Provides testing, diagnosis, or treatment of human disease or dysfunction; or

(2) Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

[(g)] (E) (1) "Office facility" means the office of one or more health care practitioners in which health care services are provided to individuals.

(2) "Office facility" includes a facility that provides:

(i) Ambulatory surgery;

(ii) Radiological or diagnostic imagery; or

(iii) Laboratory services.

(3) "Office facility" does not include any office, facility, or service operated by a hospital and regulated under [Subtitle 2 of this title] PART III OF THIS SUBTITLE.

[(h)] (F) "Payor" means:

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

(2) A health maintenance organization that holds a certificate of authority in the State; or

(3) A third party administrator as defined in § 15-111 of the Insurance Article.

19-149.

(a) The Commission shall establish a Maryland medical care data base to compile statewide data on health services rendered by health care practitioners and office facilities selected by the Commission.

(b) In addition to any other information the Commission may require by regulation, the medical care data base shall:

(1) Collect for each type of patient encounter with a health care practitioner or office facility designated by the Commission:

(i) The demographic characteristics of the patient;

(ii) The principal diagnosis;

(iii) The procedure performed;

(iv) The date and location of where the procedure was performed;

(v) The charge for the procedure;

(vi) If the bill for the procedure was submitted on an assigned or nonassigned basis; and

(vii) If applicable, a health care practitioner's universal identification number;

(2) Collect appropriate information relating to prescription drugs for each type of patient encounter with a pharmacist designated by the Commission; and

(3) Collect appropriate information relating to health care costs, utilization, or resources from payors and governmental agencies.

(c) (1) The Commission shall adopt regulations governing the access and retrieval of all medical claims data and other information collected and stored in the medical care data base and any claims clearinghouse licensed by the Commission and may set reasonable fees covering the costs of accessing and retrieving the stored data.

(2) These regulations shall ensure that confidential or privileged patient information is kept confidential.

(3) Records or information protected by the privilege between a health care practitioner and a patient, or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the person protected.

(d) (1) To the extent practicable, when collecting the data required under subsection (b) of this section, the Commission shall utilize any standardized claim form or electronic transfer system being used by health care practitioners, office facilities, and payors.

(2) The Commission shall develop appropriate methods for collecting the data required under subsection (b) of this section on subscribers or enrollees of health maintenance organizations.

(e) Until the provisions of [§ 19-1508] § 19-150 of this subtitle are fully implemented, where appropriate, the Commission may limit the data collection under this section.

(f) By October 1, 1995 and each year thereafter, the Commission shall publish an annual report on those health care services selected by the Commission that:

(1) Describes the variation in fees charged by health care practitioners and office facilities on a statewide basis and in each health service area for those health care services; and

(2) Describes the geographic variation in the utilization of those health care services.

(g) In developing the medical care data base, the Commission shall consult with[:

(1) Representatives] REPRESENTATIVES of health care practitioners, payors, and hospitals[; and

(2) Representatives of the Health Services Cost Review Commission and the Health Resources Planning Commission to ensure that the medical care data base is compatible with, may be merged with, and does not duplicate information collected by the Health Services Cost Review Commission hospital discharge data base, or data collected by the Health Resources Planning Commission as authorized in § 19-107 of this title] TO ENSURE THAT THE MEDICAL CARE DATA BASE IS COMPATIBLE WITH, MAY BE MERGED WITH, AND DOES NOT DUPLICATE INFORMATION COLLECTED BY THE COMMISSION UNDER PARTS II AND III OF THIS SUBTITLE.

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

19-150.

(a) (1) In order to more efficiently establish a medical care data base under [§ 19-1507] § 19-149 of this subtitle, the Commission shall establish standards for the operation of one or more medical care electronic claims clearinghouses in Maryland and may license those clearinghouses meeting those standards.

(2) In adopting regulations under this subsection, the Commission shall consider appropriate national standards.

(3) The Commission may limit the number of licensed claims clearinghouses to assure maximum efficiency and cost effectiveness.

(4) The Commission, by regulation, may charge a reasonable licensing fee to operate a licensed claims clearinghouse.

(5) Health care practitioners in Maryland, as designated by the Commission, shall submit, and payors of health care services in Maryland as designated by the Commission shall receive claims for payment and any other information reasonably related to the medical care data base electronically in a standard format as required by the Commission whether by means of a claims clearinghouse or other method approved by the Commission.

(6) The Commission shall establish reasonable deadlines for the phasing in of electronic transmittal of claims from those health care practitioners designated under paragraph (5) of this subsection.

(7) As designated by the Commission, payors of health care services in Maryland and Medicaid and Medicare shall transmit explanations of benefits and any other information reasonably related to the medical care data base electronically in a standard format as required by the Commission whether by means of a claims clearinghouse or other method approved by the Commission.

(b) The Commission may collect the medical care claims information submitted to any licensed claims clearinghouse for use in the data base established under [§ 19-1507] § 19-149 of this subtitle.

(c) (1) The Commission shall:

(i) On or before January 1, 1994, establish and implement a system to comparatively evaluate the quality of care outcomes and performance measurements of health maintenance organization benefit plans and services on an objective basis; and

(ii) Annually publish the summary findings of the evaluation.

(2) The purpose of a comparable performance measurement system established under this section is to assist health maintenance organization benefit plans to improve the quality of care provided by establishing a common set of performance measurements and disseminating the findings of the performance measurements to health maintenance organizations and interested parties.

(3) The system, where appropriate, shall solicit performance information from enrollees of health maintenance organizations.

(4) (i) The Commission shall adopt regulations to establish the system of evaluation provided under this section.

(ii) Before adopting regulations to implement an evaluation system under this section, the Commission shall consider any recommendations of the quality of care subcommittee of the Group Health Association of America and the National Committee for Quality Assurance.

(5) The Commission may contract with a private, nonprofit entity to implement the system required under this subsection provided that the entity is not an insurer.

19-151.

(b) (1) (I) By January 1, 1999, the Commission shall [implement] DEVELOP a payment system for all health care practitioners in the State.

(II) THE DEVELOPMENT OF THE PAYMENT SYSTEM BY THE COMMISSION UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH MAY NOT BE CONSTRUED TO AUTHORIZE THE COMMISSION TO IMPLEMENT THE PAYMENT SYSTEM.

(2) The payment system [established] DEVELOPED under this section shall include a methodology for a uniform system of health care practitioner reimbursement.

(3) Under the payment system, reimbursement for each health care practitioner shall be comprised of the following numeric factors:

(i) A numeric factor representing the resources of the health care practitioner necessary to provide health care services;

(ii) A numeric factor representing the relative value of a health care service, as classified by a code, compared to that of other health care services; and

(iii) A numeric factor representing a conversion modifier used to adjust reimbursement.

(4) To prevent overpayment of claims for surgery or services, in developing the payment system under this section, the Commission, to the extent practicable, shall establish standards to prohibit the unbundling of codes and the use of reimbursement maximization programs, commonly known as "upcoding".

(5) In developing the payment system under this section, the Commission shall consider the underlying methodology used in the resource based relative value scale established under 42 U.S.C. § 1395w-4.

(6) The Commission and the licensing boards shall develop, by regulation, appropriate sanctions, including, where appropriate, notification to the Insurance Fraud Unit of the State, for health care practitioners who violate the standards established by the Commission to prohibit unbundling and upcoding.

(c) (1) In [establishing] DEVELOPING a payment system under this section, the Commission shall take into consideration the factors listed in this subsection.

(2) In making a determination under subsection (b)(3)(i) of this section concerning the resources of a health care practitioner necessary to deliver health care services, the Commission:

(i) Shall ensure that the compensation for health care services is reasonably related to the cost of providing the health care service; and

(ii) Shall consider:

1. The cost of professional liability insurance;

2. The cost of complying with all federal, State, and local regulatory requirements;

3. The reasonable cost of bad debt and charity care;

4. The differences in experience or expertise among health care practitioners, including recognition of relative preeminence in the practitioner's field or specialty and the cost of education and continuing professional education;

5. The geographic variations in practice costs;

6. The reasonable staff and office expenses deemed necessary by the Commission to deliver health care services;

7. The costs associated with a faculty practice plan affiliated with a teaching hospital; and

8. Any other factors deemed appropriate by the Commission.

(3) In making a determination under subsection (b)(3)(ii) of this section concerning the value of a health care service relative to other health care services, the Commission shall consider:

(i) The relative complexity of the health care service compared to that of other health care services;

(ii) The cognitive skills associated with the health care service;

(iii) The time and effort that are necessary to provide the health care service; and

(iv) Any other factors deemed appropriate by the Commission.

(4) Except as provided under subsection (d) of this section, a conversion modifier shall be:

(i) A payor's standard for reimbursement;

(ii) A health care practitioner's standard for reimbursement; or

(iii) Arrangements agreed upon between a payor and a health care practitioner.

19-152.

(a) The Commission may implement a system to encourage health care practitioners to voluntarily control the costs of health care services.

(b) The Commission may require health care practitioners of selected health care specialties to cooperate with licensed operators of clinical resource management systems that allow health care practitioners to critically analyze their charges and utilization of services in comparison to their peers.

(c) If the Commission determines that clinical resource management systems are not available in the private sector, the Commission, in consultation with interested parties including payors, health care practitioners, and the Maryland Hospital Association, may develop a clinical resource management system.

(d) The Commission may adopt regulations to govern the licensing of clinical resource management systems to ensure the accuracy and confidentiality of information provided by the system.

19-153.

In any matter that relates to the utilization or cost of health care services rendered by health care practitioners or office facilities, the Commission may:

(1) Hold a public hearing;

(2) Conduct an investigation; or

(3) Require the filing of any reasonable information.

19-154.

If the Commission considers a further investigation necessary or desirable to authenticate information in a report that a health care practitioner or office facility files under this subtitle, the Commission may make necessary further examination of the records or accounts of the health care practitioner or office facility, in accordance with the regulations of the Commission.

Subtitle 4. Home Health Agencies.

19-404.

(a) The Department shall adopt rules and regulations that set standards for the care, treatment, health, safety, welfare, and comfort of patients of home health agencies.

(b) The rules and regulations shall provide for the licensing of home health agencies and annual license renewal, and shall establish standards that require as a minimum, that all home health agencies:

(1) Within 10 days of acceptance of a patient for skilled care, make and record all reasonable efforts to contact a physician to obtain the signed order required under paragraph (2) OF THIS SUBSECTION;

(2) That accept patients for skilled care do so only on the signed order of a physician obtained within 28 days after acceptance;

(3) Adopt procedures for the administration of drugs and biologicals;

(4) Maintain clinical records on all patients accepted for skilled care;

(5) Establish patient care policies and personnel policies;

(6) Have services available at least 8 hours a day, 5 days a week, and available on an emergency basis 24 hours a day, 7 days a week;

(7) Make service available to an individual in need within 24 hours of a referral when stipulated by a physician's order;

(8) Have a designated supervisor of patient care who is a full-time employee of the agency and is available at all times during operating hours and additionally as needed; and

(9) Have as the administrator of the agency a person who has at least 1 year of supervisory experience in hospital management, home health management, or public health program management and who is:

(i) A licensed physician;

(ii) A registered nurse; or

(iii) A college graduate with a bachelor's degree in a health-related field.

(c) The rules and regulations may include provisions that:

(1) Deal with the establishment of home health agencies;

(2) Require each home health agency to have its policies established by a professional group that includes at least:

(i) 1 physician;

(ii) 1 registered nurse;

(iii) 1 representative of another offered service; and

(iv) 1 public member;

(3) Govern the services provided by the home health agencies;

(4) Require keeping clinical records of each patient, including the plan of treatment to be provided;

(5) Govern supervision of the services, as appropriate, by:

(i) A physician;

(ii) A registered nurse; or

(iii) Another health professional who is qualified sufficiently by advanced training to supervise the same kind of services in a hospital; and

(6) Require submission of an annual report which includes service utilization statistics.

(d) (1) A home health agency accredited by an organization approved by the Secretary shall be deemed to meet State licensing regulations.

(2) (i) The home health agency shall submit the report of the accreditation organization to the Secretary within 30 days of its receipt.

(ii) All reports submitted under this paragraph shall be available for public inspection.

(3) The Secretary may:

(i) Inspect the home health agency for the purpose of a complaint investigation;

(ii) Inspect the home health agency to follow up on a serious problem identified in an accreditation organization's report; and

(iii) Annually, conduct a survey of up to 5 percent of all home health agencies in the State to validate the findings of an accreditation organization's report.

[(e) The provisions of this section do not waive the requirement for a home health agency to obtain a certificate of need.]

19-406.

To qualify for a license, an applicant shall[:

(1) Show] SHOW that the home health agency will provide:

[(i)] (1) Appropriate home health care to patients who may be cared for at a prescribed level of care, in their residence instead of in a hospital; and

[(ii)] (2) Skilled nursing, home health aid, and at least one other home health care service that is approved by the Secretary[; and

(2) Meet the requirements of Subtitle 1 of this title for certification of need].

Subtitle 7. Health Maintenance Organizations.

19-705.1.

(f) (5) (i) The Secretary may accept all or part of a report of an approved accrediting organization as meeting the external review requirements under this subtitle.

(ii) Except as provided in subparagraph (iii) of this paragraph, a report of an approved accrediting organization used by the Department as meeting the external review requirements under this subtitle shall be made available to the public on request.

(iii) The Department may not disclose and shall treat as confidential all confidential commercial and financial information contained in a report of an approved accrediting organization in accordance with § 10-617(d) of the State Government Article.

(iv) The Department may inspect a facility of a health maintenance organization to:

1. Determine compliance with any quality requirement established under this subtitle;

2. Follow up on a serious problem identified by an approved accrediting organization; or

3. [Investigate] IN COOPERATION WITH THE HEALTH CARE ACCESS AND COST COMMISSION, INVESTIGATE a complaint.

19-705.2.

(a) With the advice of the [Commissioner] SECRETARY, the [Secretary] HEALTH CARE ACCESS AND COST COMMISSION shall adopt regulations to establish a system for the receipt and timely investigation of complaints of members and subscribers of health maintenance organizations concerning the operation of any health maintenance organization in this State.

(b) The complaint system shall include:

(1) A procedure for the timely acknowledgement of receipt of a complaint;

(2) Criteria for determining the appropriate level of investigation for a complaint concerning quality of care, including:

(i) A determination as to whether the member or subscriber with the complaint previously attempted to have the complaint resolved; and

(ii) A determination as to whether a complaint should be sent to the member's or subscriber's health maintenance organization for resolution prior to investigation under the provisions of this section; and

(3) A procedure for the referral to the [Commissioner] HEALTH CARE ACCESS AND COST COMMISSION of all complaints [, other than quality of care complaints,] for an appropriate investigation.

(c) If a determination is made to investigate a complaint under the provisions of this section prior to the member or subscriber attempting to otherwise resolve the complaint, the reasons for that determination shall be documented.

(d) (1) Notice of the complaint system established under the provisions of this section shall be included in all contracts between a health maintenance organization and a member or subscriber of a health maintenance organization.

(2) THE NOTICE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL INCLUDE A PROVISION INFORMING A MEMBER OR SUBSCRIBER OF A HEALTH MAINTENANCE ORGANIZATION THAT IF THE MEMBER OR SUBSCRIBER HAS A COMPLAINT CONCERNING THE HEALTH MAINTENANCE ORGANIZATION THE MEMBER OR SUBSCRIBER MAY FILE A COMPLAINT WITH THE HEALTH CARE ACCESS AND COST COMMISSION.

19-728.

(D) FOR ANY MATTER RELATING TO THE INVESTIGATION OF COMPLAINTS FILED WITH THE HEALTH CARE ACCESS AND COST COMMISSION UNDER THIS SUBTITLE BY A MEMBER OR SUBSCRIBER OF A HEALTH MAINTENANCE ORGANIZATION, THE HEALTH CARE ACCESS AND COST COMMISSION AND SECRETARY SHALL COOPERATE AND SHARE INFORMATION AND RESOURCES NECESSARY TO RESOLVE ALL SUCH COMPLAINTS IN A TIMELY AND EFFICIENT MANNER.

Subtitle 9. Hospice Care Facilities.

19-906.

(a) To qualify for a license, an applicant and the hospice care program and its medical director shall meet the requirements of this section.

(b) An applicant who is an individual, and any individual who is applying on behalf of a corporation, association, or government agency shall be:

(1) At least 18 years old; and

(2) Of reputable and responsible character.

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

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

Article - Insurance

Subtitle 1. General Provisions.

15-111.

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

(2) "Health benefit plan" has the meaning stated in § 15-1201 of this title.

(3) "Payor" means:

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

(ii) a health maintenance organization that is licensed to operate in the State; or

(iii) a third party administrator or any other entity under contract with a Maryland business to administer health care benefits.

(b) (1) On or before June 30 of each year, the Commissioner shall assess each payor a fee for the next fiscal year.

(2) The fee shall be established in accordance with this section and [§ 19-1515] § 19-111 of the Health - General Article.

(c) (1) For each fiscal year, the total assessment for all payors shall be:

(i) set by a memorandum from the Maryland Health Care Access and Cost Commission; and

(ii) apportioned equitably by the Commissioner among the classes of payors described in subsection (a)(3) of this section as determined by the Commissioner.

(2) Of the total assessment apportioned under paragraph (1) of this subsection to payors described in subsection (a)(3)(i) of this section, the Commissioner shall assess each payor a fraction:

(i) the numerator of which is the payor's total premiums collected in the State for health benefit plans for an appropriate prior 12-month period as determined by the Commissioner; and

(ii) the denominator of which is the total premiums collected in the State for the same period for health benefit plans of all payors described in subsection (a)(3)(i) of this section.

(3) Of the total assessment apportioned under paragraph (1) of this subsection to payors described in subsection (a)(3)(ii) of this section, the Commissioner shall assess each payor a fraction:

(i) the numerator of which is the payor's total administrative fees collected in the State for health benefit plans for an appropriate prior 12-month period as determined by the Commissioner; and

(ii) the denominator of which is the total administrative fees collected in the State for health benefit plans for the same period of all payors described in subsection (a)(3)(ii) of this section.

(d) (1) Subject to paragraph (2) of this subsection, each payor that is assessed a fee under this section shall pay the fee to the Commissioner on or before September 1 of each year.

(2) The Commissioner, in cooperation with the Maryland Health Care Access and Cost Commission, may provide for partial payments.

(e) The Commissioner shall distribute the fees collected under this section to the Health Care Access and Cost Fund established under [§ 19-1515] § 19-111 of the Health - General Article.

(f) Each payor shall cooperate fully in submitting reports and claims data and providing any other information to the Maryland Health Care Access and Cost Commission in accordance with [Title 19, Subtitle 15] TITLE 19, SUBTITLE 1 of the Health - General Article.

[(g) Each payor shall pay for health care services in accordance with the payment system adopted under § 19-1509 of the Health - General Article.]

Subtitle 10. Claims and Utilization Review.

15-1001.

(a) This section applies to insurers and nonprofit health service plans that propose to issue or deliver individual, group, or blanket health insurance policies or contracts in the State or to administer health benefit programs that provide for the coverage of hospital benefits and the utilization review of those benefits.

(b) Each entity subject to this section shall:

(1) have a certificate issued under [Title 19, Subtitle 13 of the Health - General Article] SUBTITLE 10A OF THIS TITLE;

(2) contract with a private review agent that has a certificate issued under [Title 19, Subtitle 13 of the Health - General Article] SUBTITLE 10A OF THIS TITLE; or

(3) contract with or delegate utilization review to a hospital utilization review program approved under § 19-319(d) of the Health - General Article.

(c) Notwithstanding any other provision of this article, if the medical necessity of providing a covered benefit is disputed, an entity subject to this section that does not meet the requirements of subsection (b) of this section shall pay any person entitled to reimbursement under the policy, contract, or certificate in accordance with the determination of medical necessity by the hospital utilization review program approved under § 19-319(d) of the Health - General Article.

Subtitle 10A. Private Review Agents.

15-10A-01.

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

(b) (1) "Adverse decision" means a utilization review determination made by a private review agent that a proposed or delivered health care service:

(i) Is or was not necessary, appropriate, or efficient; and

(ii) May result in noncoverage of the health care service.

(2) There is no adverse decision if the private review agent and the health care provider on behalf of the patient reach an agreement on the proposed or delivered health care services.

(C) "CERTIFICATE" MEANS A CERTIFICATE OF REGISTRATION GRANTED BY THE COMMISSIONER TO A PRIVATE REVIEW AGENT.

[(c)] (D) (1) "Employee assistance program" means a health care service plan that, in accordance with a contract with an employer or labor union:

(i) Consults with employees or members of an employee's family or both to:

1. Identify the employee's or the employee's family member's mental health, alcohol, or substance abuse problems; and

2. Refer the employee or the employee's family member to health care providers or other community resources for counseling, therapy, or treatment; and

(ii) Performs utilization review for the purpose of making claims or payment decisions on behalf of the employer's or labor union's health insurance or health benefit plan.

(2) "Employee assistance program" does not include a health care service plan operated by a hospital solely for employees, or members of an employee's family, of that hospital.

[(d)] (E) "Health care facility" means:

(1) A hospital as defined in § 19-301 of [this title] THE HEALTH - GENERAL ARTICLE;

(2) A related institution as defined in § 19-301 of [this title] THE HEALTH - GENERAL ARTICLE;

(3) An ambulatory surgical facility or center which is any entity or part thereof that operates primarily for the purpose of providing surgical services to patients not requiring hospitalization and seeks reimbursement from third party payors as an ambulatory surgical facility or center;

(4) A facility that is organized primarily to help in the rehabilitation of disabled individuals;

(5) A home health agency as defined in § 19-401 of [this title] THE HEALTH - GENERAL ARTICLE;

(6) A hospice as defined in § 19-901 of [this title] THE HEALTH - GENERAL ARTICLE;

(7) A facility that provides radiological or other diagnostic imagery services;

(8) A medical laboratory as defined in § 17-201 of [this article] THE HEALTH - GENERAL ARTICLE; or

(9) An alcohol abuse and drug abuse treatment program as defined in § 8-403 of [this article] THE HEALTH - GENERAL ARTICLE.

(F) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL PROCEDURE OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

(1) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION; OR

(2) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

[(e) "Utilization review" means a system for reviewing the appropriate and efficient allocation of hospital resources and services given or proposed to be given to a patient or group of patients.]

[(f)] (G) "Private review agent" means:

(1) A nonhospital-affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of:

(i) A Maryland business entity; or

(ii) A third party that provides or administers hospital, OUTPATIENT, MEDICAL, OR OTHER benefits to citizens of this State, including:

1. A health maintenance organization issued a certificate of authority in accordance with Subtitle 7 of [this title] THE HEALTH - GENERAL ARTICLE; or

2. A health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization authorized to offer health insurance policies or contracts in this State in accordance with [the Insurance Article] THIS ARTICLE; or

(2) Any person or entity including a hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees:

(i) Employed by the hospital; or

(ii) Employed by a business wholly owned by the hospital.

[(g)] (H) "Significant beneficial interest" means the ownership of any financial interest that is greater than the lesser of:

(1) 5 percent of the whole; or

(2) $5,000.

(I) "UTILIZATION REVIEW" MEANS A SYSTEM FOR REVIEWING THE APPROPRIATE AND EFFICIENT ALLOCATION OF HEALTH CARE SERVICES GIVEN OR PROPOSED TO BE GIVEN TO A PATIENT OR GROUP OF PATIENTS.

[(h)] (J) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.

[(i) "Secretary" means the Secretary of Health and Mental Hygiene.]

[(j) "Commissioner" means the Insurance Commissioner.]

[(k) "Certificate" means a certificate of registration granted by the Secretary to a private review agent.]

15-10A-03.

(a) A private review agent may not conduct utilization review in this State unless the [Secretary] COMMISSIONER has granted the private review agent a certificate.

(b) The [Secretary] COMMISSIONER shall issue a certificate to an applicant that has met all the requirements of this subtitle and all applicable regulations of the [Secretary] COMMISSIONER.

[(c) The Secretary may delegate the authority to issue a certificate to the Commissioner for any health insurer or nonprofit health service plan regulated under the Insurance Article or health maintenance organization issued a certificate of authority in accordance with Subtitle 7 of this title that meets the requirements of this subtitle and all applicable regulations of the Secretary.]

[(d)] (C) A certificate issued under this subtitle is not transferable.

[(e)] (D) (1) The [Secretary] COMMISSIONER, after consultation with [the Commissioner,] payors, including the Health Insurance Association of America and the Maryland Association of Health Maintenance Organizations, and providers of health care, including the Maryland Hospital Association, the Medical and Chirurgical Faculty of Maryland, and licensed or certified providers of treatment for a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder, shall adopt regulations to implement the provisions of this subtitle.

(2) (i) Subject to the provisions of subparagraph (iii) of this paragraph, the regulations adopted by the [Secretary] COMMISSIONER shall include a uniform treatment plan form for utilization review of services for the treatment of a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder.

(ii) The uniform treatment plan form adopted by the [Secretary] COMMISSIONER:

1. Shall adequately protect the confidentiality of the patient; and

2. May only request the patient's membership number, policy number, or other similar unique patient identifier and first name for patient identification.

(iii) The [Secretary] COMMISSIONER may waive the requirements of regulations adopted under subparagraph (i) of this paragraph for the use of a uniform treatment plan form for any entity that would be using the form solely for internal purposes.

15-10A-04.

(a) An applicant for a certificate shall:

(1) Submit an application to the [Secretary] COMMISSIONER; and

(2) Pay to the [Secretary] COMMISSIONER the application fee established by the [Secretary] COMMISSIONER through regulation.

(b) The application shall:

(1) Be on a form and accompanied by any supporting documentation that the [Secretary] COMMISSIONER requires; and

(2) Be signed and verified by the applicant.

(c) The application fees required under subsection (a)(2) of this section or [§ 19-1306(b)(2)] § 15-10A-10(B)(2) of this subtitle shall be sufficient to pay for the administrative costs of the certificate program and any other costs associated with carrying out the provisions of this subtitle.

15-10A-05.

(a) In conjunction with the application, the private review agent shall submit information that the [Secretary] COMMISSIONER requires including:

(1) A utilization review plan that includes:

(i) The specific criteria and standards to be used in conducting utilization review of proposed or delivered services;

(ii) Those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; and

(iii) The provisions by which patients, physicians, or hospitals may seek reconsideration or appeal of adverse decisions by the private review agent;

(2) The type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) The procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and providers 5 days a week during normal business hours in this State;

(4) The policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual medical records are followed;

(5) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

(6) A list of the third party payors for which the private review agent is performing utilization review in this State;

(7) The policies and procedures to ensure that the private review agent has a formal program for the orientation and training of the personnel either employed or under contract to perform the utilization review;

(8) A list of the health care providers involved in establishing the specific criteria and standards to be used in conducting utilization review; and

(9) Certification by the private review agent that the criteria and standards to be used in conducting utilization review are:

(i) Objective;

(ii) Clinically valid;

(iii) Compatible with established principles of health care; and

(iv) Flexible enough to allow deviations from norms when justified on a case by case basis.

(b) At least 10 days before a private review agent requires any revisions or modifications to the specific criteria and standards to be used in conducting utilization review of proposed or delivered services, the private review agent shall submit those revisions or modifications to the [Secretary] COMMISSIONER.

15-10A-06.

(a) In this section, "utilization review" means a system for reviewing the appropriate and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients by a health care provider, including a hospital or an intermediate care facility described under § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE.

(e) (1) In the event a patient or health care provider, including a physician, intermediate care facility described under § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision by a private review agent, the final determination of the appeal of the adverse decision shall be made based on the professional judgment of a physician, or a panel of other appropriate health care providers with at least 1 physician, selected by the private review agent who is:

(i) 1. Board certified or eligible in the same specialty as the treatment under review; or

2. Actively practicing or has demonstrated expertise in the alcohol, drug abuse, or mental health service or treatment under review; and

(ii) Not compensated by the private review agent in a manner that provides a financial incentive directly or indirectly to deny or reduce coverage.

(2) In the event a patient or health care provider, including a physician, intermediate care facility described under § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision by a private review agent, the final determination of the appeal of the adverse decision shall be stated in writing and shall reference the specific criteria and standards, including interpretive guidelines, upon which the denial or reduction in coverage is based.

(g) (1) A private review agent that requires a health care provider to submit a treatment plan in order for the private review agent to conduct utilization review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder:

(i) Shall accept the uniform treatment plan form adopted by the [Secretary under § 19-1303(e)] COMMISSIONER UNDER § 15-10A-03(E) of this subtitle as a properly submitted treatment plan form; and

(ii) May not impose any requirement to:

1. Modify the uniform treatment plan form or its content; or

2. Submit additional treatment plan forms.

(2) A uniform treatment plan form submitted under the provisions of this subsection:

(i) Shall be properly completed by the health care provider; and

(ii) May be submitted by electronic transfer.

15-10A-07.

(a) Except as specifically provided in [§ 19-1305.1] § 15-10A-06 of this subtitle:

(1) All adverse decisions shall be made by a physician or a panel of other appropriate health care providers with at least 1 physician on the panel.

(2) In the event a patient or health care provider, including a physician, intermediate care facility described in § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision by a private review agent, the final determination of the appeal of the adverse decision shall be made based on the professional judgment of a physician or a panel of other appropriate health care providers with at least 1 physician on the panel.

(3) In the event a patient or health care provider, including a physician, intermediate care facility described in § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision by a private review agent, the final determination of the appeal of the adverse decision shall:

(i) Be stated in writing and provide an explanation of the reason for the adverse decision; and

(ii) Reference the specific criteria and standards, including interpretive guidelines, upon which the adverse decision is based.

15-10A-09.

(e) (1) The private review agent or health maintenance organization may not require additional documentation from, require additional utilization review of, or otherwise provide financial disincentives for an attending provider who orders care for which coverage is required to be provided under this section, § 19-703 of [this article] THE HEALTH - GENERAL ARTICLE, or § 15-811 of [the Insurance Article] THIS ARTICLE.

15-10A-10.

(a) A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a 2-year term as provided in this section.

(b) Before the certificate expires, a certificate may be renewed for an additional 2-year term if the applicant:

(1) Otherwise is entitled to the certificate;

(2) Pays to the [Secretary] COMMISSIONER the renewal fee set by the [Secretary] COMMISSIONER through regulation; and

(3) Submits to the [Secretary] COMMISSIONER:

(i) A renewal application on the form that the [Secretary] COMMISSIONER requires; and

(ii) Satisfactory evidence of compliance with any requirement under this subtitle for certificate renewal.

(c) If the requirements of this section are met, the [Secretary] COMMISSIONER shall renew a certificate.

[(d) The Secretary may delegate to the Commissioner the authority to renew a certificate to any health insurer or nonprofit health service plan regulated under the Insurance Article or health maintenance organization issued a certificate of authority in accordance with Subtitle 7 of this title that meets the requirements of this subtitle and all applicable regulations of the Secretary.]

15-10A-11.

(a) (1) The [Secretary] COMMISSIONER shall deny a certificate to any applicant if, upon review of the application, the [Secretary] COMMISSIONER finds that the applicant proposing to conduct utilization review does not:

(i) Have available the services of sufficient numbers of registered nurses, medical records technicians or similarly qualified persons supported and supervised by appropriate physicians to carry out its utilization review activities; and

(ii) Meet any applicable regulations the [Secretary] COMMISSIONER adopts under this subtitle relating to the qualifications of private review agents or the performance of utilization review.

(2) The [Secretary] COMMISSIONER shall deny a certificate to any applicant that does not provide assurances satisfactory to the [Secretary] COMMISSIONER that:

(i) The procedures and policies of the private review agent will protect the confidentiality of medical records in accordance with applicable State and federal laws; and

(ii) The private review agent will be accessible to patients and providers 5 working days a week during normal business hours in this State.

(b) The [Secretary] COMMISSIONER may revoke a certificate if the holder does not comply with performance assurances under this section, violates any provision of this subtitle, or violates any regulation adopted under any provision of this subtitle.

(c) (1) Before denying or revoking a certificate under this section, the [Secretary] COMMISSIONER shall provide the applicant or certificate holder with reasonable time to supply additional information demonstrating compliance with the requirements of this subtitle and the opportunity to request a hearing.

(2) If an applicant or certificate holder requests a hearing, the [Secretary] COMMISSIONER shall send a hearing notice by certified mail, return receipt requested, at least 30 days before the hearing.

(3) The [Secretary] COMMISSIONER shall hold the hearing in accordance with Title 10, Subtitle 2 of the State Government Article.

15-10A-12.

The [Secretary] COMMISSIONER may waive the requirements of this subtitle for a private review agent that operates solely under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act.

15-10A-13.

The [Secretary] COMMISSIONER shall periodically provide a list of private review agents issued certificates and the renewal date for those certificates to:

(1) The Maryland Chamber of Commerce;

(2) The Medical and Chirurgical Faculty of Maryland;

(3) The Maryland Hospital Association;

(4) All hospital utilization review programs; and

(5) Any other business or labor organization requesting the list.

15-10A-14.

The [Secretary] COMMISSIONER may establish reporting requirements to:

(1) Evaluate the effectiveness of private review agents; and

(2) Determine if the utilization review programs are in compliance with the provisions of this section and applicable regulations.

15-10A-17.

(b) (1) In addition to the provisions of subsection (a) of this section, the [Secretary] COMMISSIONER may impose an administrative penalty of up to $1,000 for a violation of any provision of this subtitle.

(2) The [Secretary] COMMISSIONER shall adopt regulations to provide standards for the imposition of an administrative penalty under paragraph (1) of this subsection.

15-10A-18.

(a) Any person aggrieved by a final decision of the [Secretary] COMMISSIONER in a contested case under this subtitle may take a direct judicial appeal.

Article 43C - Maryland Health and Higher Educational Facilities Authority

16A.

(a) In this section, the following terms have the meanings indicated.

(1) "Closure costs" means the reasonable costs determined by the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION to be incurred in connection with the closure or delicensure of a hospital, including expenses of operating the hospital, payments to employees, employee benefits, fees of consultants, insurance, security services, utilities, legal fees, capital costs, costs of terminating contracts with vendors, suppliers of goods and services and others, debt service, contingencies and other necessary or appropriate costs and expenses.

(2) (i) "Public body obligation" means any bond, note, evidence of indebtedness or other obligation for the payment of borrowed money issued by the Authority, any public body as defined in Article 31, § 9 of the Code, the Mayor and

City Council of Baltimore, or any municipal corporation subject to the provisions of Article XI-E of the Maryland Constitution.

(ii) "Public body obligation" does not include any obligation, or portion of any such obligation, if:

1. The principal of and interest on the obligation or such portion thereof is:

A. Insured by an effective municipal bond insurance policy; and

B. Issued on behalf of a hospital that voluntarily closed in accordance with [§ 19-115(l)] § 19-121(L) of the Health - General Article;

2. The proceeds of the obligation or such portion thereof were used for the purpose of financing or refinancing a facility or part thereof which is used primarily to provide outpatient services at a location other than the hospital; or

3. The proceeds of the obligation or such portion thereof were used to finance or refinance a facility or part thereof which is primarily used by physicians who are not employees of the hospital for the purpose of providing services to nonhospital patients.

(b) (1) The General Assembly finds that the failure to provide for the payment of public body obligations of a closed or delicensed hospital could have a serious adverse effect on the ability of Maryland health care facilities, and potentially the ability of the State and local governments, to secure subsequent financing through the issuance of tax-exempt bonds.

(2) The purpose of this section is to preserve the access of Maryland's health care facilities to adequate financing by establishing a program to facilitate the refinancing and payment of public body obligations of a closed or delicensed hospital.

(c) The Maryland Hospital Bond Program is hereby created within the Maryland Health and Higher Educational Facilities Authority. The Program shall provide for the payment and refinancing of public body obligations of a hospital, as defined in § 19-301 of the Health - General Article, if:

(1) The closure of a hospital is in accordance with [§ 19-115(l)] § 19-121(L) of the Health - General Article or the delicensure of a hospital is in accordance with § 19-325 of the Health - General Article;

(2) There are public body obligations issued on behalf of the hospital outstanding;

(3) The closure of the hospital is not the result of a merger or consolidation with 1 or more other hospitals; and

(4) The hospital plan for closure or delicensure and the related financing or refinancing plan is acceptable to the Secretary of Health and Mental Hygiene and the Authority.

(d) (1) The [Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION shall give:

(i) The Authority [and the Health Services Cost Review Commission] written notification of the filing by a hospital with the [Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION of any written notice of intent to close under[§ 19-115(l)] § 19-121(L) of the Health - General Article; or

(ii) The Authority written notification of the filing with the Secretary of Health and Mental Hygiene of a petition for the delicensure of a hospital under § 19-325 of the Health - General Article.

(2) The notice required by this subsection shall be given within 10 days after the filing of the notice or petition.

(e) (1) The [Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION and the Secretary of Health and Mental Hygiene shall give the Authority [and the Health Services Cost Review Commission] written notification of:

(i) A determination by the [Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION to exempt a hospital closure from the certificate of need requirement pursuant to [§ 19-115(l)] § 19-121(L) of the Health - General Article; or

(ii) A determination by the Secretary of Health and Mental Hygiene to delicense a hospital pursuant to § 19-325 of the Health - General Article.

(2) The [Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION and the Secretary of Health and Mental Hygiene shall submit the written notification required in paragraph (1) of this subsection no later than 150 days prior to the scheduled date of the hospital closure or delicensure and shall include the name and location of the hospital, and the scheduled date of hospital closure or delicensure.

(f) (1) A hospital that intends to close or is scheduled to be delicensed shall provide the Authority and the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION with a written statement of any outstanding public body obligations issued on behalf of the hospital, which shall include:

(i) The name of each issuer of a public body obligation on behalf of the hospital;

(ii) The outstanding principal amount of each public body obligation and the due dates for payment or any mandatory redemption or purchase thereof;

(iii) The due dates for the payment of interest on each public body obligation and the interest rates; and

(iv) Any documents and information pertaining to the public body obligations as the Authority or the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION may request.

(2) The statement required in paragraph (1) of this subsection shall be filed by the hospital:

(i) In the case of closure pursuant to [§ 19-115(l)] § 19-121(L) of the Health - General Article, within 10 days after the date of filing with the [Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION of written notice of intent to close; or

(ii) In the case of delicensure pursuant to § 19-325 of the Health - General Article, at least 150 days prior to the scheduled date of delicensure.

(g) (1) The [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION may determine to provide for the payment of all or any portion of the closure costs of a hospital having outstanding public body obligations if the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION determines that payment of the closing costs is necessary or appropriate to:

(i) Encourage and assist the hospital to close; or

(ii) Implement the program created by this section.

(2) In making the determinations under this subsection, the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION shall consider:

(i) The amount of the system-wide savings to the State health care system expected to result from the closure or delicensure of the hospital over:

1. The period during which the fee to provide for the payment of the closure costs or any bonds or notes issued to finance the closure costs will be assessed; or

2. A period ending 5 years after the date of closure or delicensure, whichever is the longer; and

(ii) The recommendations of [the Health Resources Planning Commission and] the Authority.

(3) Within 60 days after receiving the notice of closure or delicensure required by subsection (e) OF THIS SECTION, the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION shall:

(i) Determine whether to provide for the payment of all or any portion of the closure costs of the hospital in accordance with this subsection; and

(ii) Give written notification of such determination to [the Health Resources Planning Commission and] the Authority.

(4) The provisions of this subsection may not be construed to require the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION to make provision for the payment of any closure costs of a closed or delicensed hospital.

(5) In any suit, action or proceeding involving the validity or enforceability of any bond or note issued to finance any closure costs or any security for a bond or note, the determinations of the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION under this subsection shall be conclusive and binding.

(h) (1) Within 60 days after receiving the written statement required by subsection (f) of this section, the Authority shall prepare a schedule of payments necessary to meet the public body obligations of the hospital.

(2) As soon as practicable after receipt of the notice of closure or delicensure required by subsection (e) and after consultation with the issuer of each public body obligation and the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION, the Authority shall prepare a proposed plan to finance, refinance or otherwise provide for the payment of public body obligations. The proposed plan may include any tender, redemption, advance refunding or other technique deemed appropriate by the Authority.

(3) As soon as practicable after receipt of written notification that the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION has determined to provide for the payment of any closure costs of a hospital pursuant to subsection (g) of this section, the Authority shall prepare a proposed plan to finance, refinance or otherwise provide for the payment of the closure costs set forth in the notice.

(4) Upon the request of the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION, the Authority may begin preparing the plan or plans required by this subsection before:

(i) The final determination by the [Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION to exempt a hospital closure from the certificate of need requirement pursuant to [§ 19-115(l)] § 19-121(L) of the Health - General Article;

(ii) Any final determination of delicensure by the Secretary of Health and Mental Hygiene pursuant to § 19-325 of the Health - General Article; or

(iii) Any final determination by the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION to provide for the payment of any closure costs of the hospital.

(5) The Authority shall promptly submit the schedule of payments and the proposed plan or plans required by this subsection to the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION.

(i) (1) The Authority may issue negotiable bonds or notes for the purpose of financing, refinancing or otherwise providing for the payment of public body obligations or any closure costs of a hospital in accordance with any plan developed pursuant to subsection (h) of this section.

(2) The bonds or notes shall be payable from the fees provided pursuant to subsection (j) of this section or from other sources as may be provided in the plan.

(3) The bonds or notes shall be authorized, sold, executed and delivered as provided for in this article and shall have terms consistent with all existing constitutional and legal requirements.

(4) In connection with the issuance of any bond or note, the Authority may assign its rights under any loan, lease or other financing agreement between the Authority or any other issuer of a public body obligation and the closed or delicensed hospital to the State or appropriate agency in consideration for the payment of any public body obligation as provided in this section.

(j) (1) On the date of closure or delicensure of any hospital for which a financing or refinancing plan has been developed in accordance with subsection (h) of this section, the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION shall assess a fee on all hospitals as provided in [§ 19-207.2] § 19-143 of the Health - General Article in an amount sufficient to:

(i) Pay the principal and interest on any public body obligations, or any bonds or notes issued by the Authority pursuant to subsection (i) of this section to finance or refinance public body obligations;

(ii) Pay any closure costs or the principal and interest on any bonds or notes issued by the Authority pursuant to subsection (i) of this section to finance or refinance any closure costs;

(iii) Maintain any reserve required in the resolution, trust agreement or other financing agreement securing public body obligations, bonds, or notes;

(iv) Pay any required financing fees or other similar charges; and

(v) Maintain reserves deemed appropriate by the Authority to ensure that the amounts provided in this subsection are satisfied in the event any hospital defaults in paying the fees.

(2) The fee assessed each hospital shall be equal to that portion of the total fees required to be assessed that is equal to the ratio of the actual gross patient revenues of the hospital to the total gross patient revenues of all hospitals, determined as of the date or dates deemed appropriate by the Authority after consultation with the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION.

(3) Each hospital shall pay the fee directly to the Authority, any trustee for the holders of any bonds or notes issued by the Authority pursuant to subsection (i) of this section, or as otherwise directed by the Authority. The fee may be assessed at any time necessary to meet the payment requirements of this subsection.

(4) The fees assessed may not be subject to supervision or regulation by any department, commission, board, body or agency of this State. Any pledge of these fees to any bonds or notes issued pursuant to this section or to any other public body obligations, shall immediately subject such fees to the lien of the pledge without any physical delivery or further act. The lien of the pledge shall be valid and binding against all parties having claims of any kind in tort, contract or otherwise against the Authority or any closed or delicensed hospital, irrespective of whether the parties have notice.

(5) In the event the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION shall terminate by Law, the Secretary of Health and Mental Hygiene, in accordance with the provisions of this subsection, shall impose a fee on all hospitals licensed pursuant to § 19-318 of the Health - General Article.

(k) (1) Notwithstanding any other provision of this article, any action taken by the Authority to provide for the payment of public body obligations shall be for the purpose of maintaining the credit rating of this State, its agencies, instrumentalities, and political subdivisions, ensuring their access to the credit markets, and may not constitute any payment by or on behalf of a closed or delicensed hospital. A hospital is not relieved of its obligations with respect to the payment of public body obligations. The Authority shall be subrogated to the rights of any holders or issuers of public body obligations, as if the payment or provision for payment had not been made.

(2) The Authority may proceed against any guaranty or other collateral securing the payment of public body obligations of a closed or delicensed hospital which was provided by any entity associated with the hospital if such action is determined by the Authority to be:

(i) Necessary to protect the interests of the holders of the public body obligations; or

(ii) Consistent with the public purpose of encouraging and assisting the hospital to close.

(3) In making the determination required under paragraph (2) of this subsection, the Authority shall consider:

(i) The circumstances under which the guaranty or other collateral was provided; and

(ii) The recommendations of the [Health Services Cost Review Commission and the Health Resources Planning Commission] HEALTH CARE ACCESS AND COST COMMISSION.

(4) Any amount realized by the Authority or any assignee of the Authority in the enforcement of any claim against a hospital for which a plan has been developed in accordance with subsection (h) of this section shall be applied to offset the amount of the fee required to be assessed by the [Health Services Cost Review Commission] HEALTH CARE ACCESS AND COST COMMISSION pursuant to subsection (j) of this section. The costs and expenses of enforcing the claim, including any costs for maintaining the property prior to its disposition, shall be deducted from this amount.

(l) It is the purpose and intent of this section that the [Health Services Cost Review Commission, the Health Resources Planning Commission,] HEALTH CARE ACCESS AND COST COMMISSION and the Authority consult with each other and take into account each others' recommendations in making the determinations required to be made under this section.

(m) Notwithstanding any other provision of this section, in any suit, action or proceeding involving the validity or enforceability of any bond or note or any security for a bond or note, the determinations of the Authority under this section shall be conclusive and binding.

(n) The [Health Services Cost Review Commission, the Health Resources Planning Commission,] HEALTH CARE ACCESS AND COST COMMISSION or the Authority may waive any notice required to be given to it under this section.

Chapter 134 of the Acts of 1997

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

(1) The] THE Maryland Health Care Access and Cost Commission may not implement the provisions of [§ 19-1509(b)] § 19-151(B) of the Health - General Article [before January 1, 1998; and

(2) If the Maryland Health Care Access and Cost Commission decides to implement the provisions of § 19-1509(b) of the Health - General Article, the Maryland Health Care Access and Cost Commission, in accordance with § 10-111 of the State Government Article, shall submit for emergency adoption proposed regulations that would carry out the provisions of § 19-1509(b) of the Health - General Article on or before January 1, 1999].

SECTION 5. AND BE IT FURTHER ENACTED, That the Health Care Access and Cost Commission shall:

(a) conduct a study of the certificate of need program to determine:

(1) the necessity of requiring a certificate of need for building, establishing, developing, or operating new medical services, health care projects, or health care facilities for which a certificate of need is required;

(2) the necessity of requiring a certificate of need when modifying or changing the type or scope of health care services for which a certificate of need is required; and

(3) the possibility of further consolidating, modifying, or streamlining the certificate of need application process for those situations that the Commission determines a certificate of need is necessary; and

(b) on or before December 1, 1998, submit a report of its study, including its recommendations, to the Governor, the Senate Finance Committee, the House Economic Matters Committee, and the House Environmental Matters Committee.

SECTION 6. AND BE IT FURTHER ENACTED, That:

(a) on or before September 1, 1998, the Maryland Health Care Access and Cost Commission shall contract with an independent entity to conduct a study of the Maryland Health Care Access and Cost Commission's management and organization;

(b) the focus of the study shall be to review and examine the operations, organizational structure, processes, funding mechanism, and staffing of the Maryland Health Care Access and Cost Commission after completion of the reorganization provided for under this Act; and

(c) on or before January 1, 1999, a report on the results of the study, including any legislative proposals and recommendations, shall be submitted to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

SECTION 7. AND BE IT FURTHER ENACTED, That:

(a) all property of any kind, including personal property, records, fixtures, appropriations, credits, assets, liabilities, obligations, rights, and privileges, held by the State Health Resources Planning Commission and the State Health Services Cost Review Commission shall be and hereby are transferred to the Maryland Health Care Access and Cost Commission;

(b) except as otherwise provided by law, all contracts, agreements, grants, or other obligations entered into prior to July 1, 1998 by the State Health Resources Planning Commission or the State Health Services Cost Review Commission, and which by their terms are to continue in effect on or after July 1, 1998, shall be valid, legal, and binding obligations of the Maryland Health Care Access and Cost Commission, under the terms of the obligations; and

(c) any transaction affected by any change of nomenclature under this Act, and validly entered into before July 1, 1998, and every right, duty, or interest flowing from the transaction, remains valid on and after July 1, 1998 as if the change of nomenclature had not occurred.

SECTION 8. AND BE IT FURTHER ENACTED, That all employees who are transferred to the Maryland Health Care Access and Cost Commission from the State Health Resources Planning Commission and the State Health Services Cost Review Commission upon the implementation of this Act shall be so transferred without diminution of their rights, benefits, or employment or retirement status.

SECTION 9. AND BE IT FURTHER ENACTED, That:

(a) The publishers of the Annotated Code of Maryland, subject to the approval of the Department of Legislative Services, shall propose the correction of any agency names and titles throughout the Code that are rendered incorrect by this Act; and

(b) Subject to the approval of the Director of the Department of Legislative Services, the publishers of the Annotated Code of Maryland shall correct any cross-references that are rendered incorrect by this Act.

SECTION 10. AND BE IT FURTHER ENACTED, That Sections 5 and 6 of this Act shall take effect June 1, 1998.

SECTION 11. AND BE IT FURTHER ENACTED, That, except as provided in Section 10 of this Act, this Act shall take effect July 1, 1998.