SENATE BILL 521

Unofficial Copy 1998 Regular Session
J1 8lr1926

By: **Senator Teitelbaum**
Introduced and read first time: February 6, 1998
Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Care Regulatory Reform**

3 FOR the purpose of integrating, consolidating, and streamlining certain health care
4 regulatory responsibilities and duties under the State Health Care Access and
5 Systems Performance Commission; specifying the purpose of this Act; abolishing
6 certain commissions that function in the Department of Health and Mental
7 Hygiene; establishing the State Health Care Access and Systems Performance
8 Commission; specifying the duties, responsibilities, and functions of the
9 Commission; specifying the terms and membership of the Commission;
10 requiring the Commission to appoint an Executive Director; specifying the
11 qualifications of the Executive Director; establishing the Health Care Access
12 and Systems Performance Commission Fund; specifying funding for the Fund;
13 altering certain provisions of law related to health planning and development;
14 repealing requirements for certain health care facilities to obtain a certificate of
15 need when changing the type and scope of health care services, changing bed
16 capacity, relocating, or merging or closing under certain circumstances;
17 repealing the requirement that a certificate of need be obtained for establishing
18 certain health care facilities under certain circumstances; authorizing the
19 Commission to adopt certain regulations to establish a certain method and
20 mechanism to finance the cost of uncompensated care for the types of
21 procedures and services provided by ambulatory surgical facilities under certain
22 circumstances; establishing the classification of "limited service hospital" for
23 certain health care facilities; specifying that a certificate of need is not required
24 for the conversion of a hospital to a limited service hospital; establishing the
25 Quality Management Administration in the Department; specifying the duties
26 and responsibilities of the Administration; altering the purpose and
27 responsibilities of the Advisory Committee on Practice Parameters; transferring
28 the administrative and enforcement responsibility for private review agents to
29 the Insurance Commissioner; altering a certain requirement to require the
30 Insurance Commissioner to adopt certain health benefit plans; providing for the
31 evaluation of the State Health Care Access and Systems Performance
32 Commission in accordance with the Maryland Program Evaluation Act;
33 requiring the Secretary of Health and Mental Hygiene, the State Insurance
34 Commissioner, and the Health Care Access and Systems Performance
35 Commission to cooperate with each other in a certain manner, conduct certain

1 meetings, and submit certain reports; requiring the State Health Care Access
2 and Systems Performance Commission to submit a certain report by a certain
3 date concerning the replacement of the certificate of need program; specifying
4 certain transitional provisions relating to the implementation of the provisions
5 of this Act; providing for the accurate codification of the provisions of this Act;
6 making certain technical changes; defining certain terms; altering certain
7 definitions; and generally relating to the integrating, consolidation, and
8 streamlining of certain health care regulatory responsibilities and duties.

9 BY repealing
10 Article - Health - General
11 Section 19-102 through 19-109, 19-121, 19-122, and 19-126, the part "Part I.
12 Health Planning and Development", and the subtitle "Subtitle 1.
13 Comprehensive Health Planning"; 19-202 through 19-207.1, 19-208, and
14 19-222 and the subtitle "Subtitle 2. Health Services Cost Review
15 Commission"; 19-1502 through 19-1506, 19-1509 through 19-1512, and
16 19-1515 and the subtitle "Subtitle 15. Maryland Health Care Access and
17 Cost Commission"; and 19-1606
18 Annotated Code of Maryland
19 (1996 Replacement Volume and 1997 Supplement)

20 BY renumbering
21 Article - Health - General
22 Section 19-125 and the part "Part II. Deficiencies in Services and Facilities",
23 respectively
24 Annotated Code of Maryland
25 (1996 Replacement Volume and 1997 Supplement)
26 to be Section 2-108 and the part "Part II. Deficiencies in Services and
27 Facilities", respectively
28 Annotated Code of Maryland
29 (1994 Replacement Volume and 1997 Supplement)

30 BY renumbering
31 Article - Health - General
32 Section 19-101, 19-110 through 19-120, 19-123, 19-201, 19-209, 19-210,
33 19-207.3, 19-211 through 19-213, 19-216 through 19-219, 19-207.2,
34 19-220, 19-214, 19-215, 19-221, 19-1501, 19-1507, 19-1508, 19-1516,
35 19-1513, and 19-1514, respectively
36 to be Section 19-111, 19-114 through 19-126, and 19-127 to be under the new
37 part "Part II. Health Planning and Development"; 19-128, 19-130,
38 19-131, 19-132, 19-134 through 19-137, 19-138 through 19-141, 19-142,
39 19-143, 19-144, 19-145, and 19-146 to be under the new part "Part III.
40 Health Care Facility Rate Setting"; 19-147, 19-148, 19-149, 19-150,
41 19-151, and 19-152 to be under the new part "Part IV. Medical Care Data
42 Collection", respectively
43 Annotated Code of Maryland

1 (1996 Replacement Volume and 1997 Supplement)

2 BY transferring
3 Article - Health - General
4 Section 19-1301 through 19-1305, 19-1305.1, 19-1305.2, 19-1305.3,
5 19-1305.4, and 19-1306 through 19-1313 and the subtitle "Subtitle 13.
6 Private Review Agents", respectively
7 Annotated Code of Maryland
8 (1996 Replacement Volume and 1997 Supplement)
9 to be
10 Article - Insurance
11 Section 15-9A-01 through 15-9A-18 and the subtitle "Subtitle 9A. Private
12 Review Agents", respectively
13 Annotated Code of Maryland
14 (1997 Volume)

15 BY repealing
16 Article - Insurance
17 Section 15-605(e) and 15-1201(d)
18 Annotated Code of Maryland
19 (1997 Volume)

20 BY repealing
21 Article - State Government
22 Section 8-403(i)
23 Annotated Code of Maryland
24 (1995 Replacement Volume and 1997 Supplement)

25 BY adding to
26 Article - Health - General
27 Section 1-301 to be under the new subtitle "Subtitle 3. Miscellaneous
28 Provisions"
29 Annotated Code of Maryland
30 (1994 Replacement Volume and 1997 Supplement)

31 BY repealing and reenacting, without amendments,
32 Article - Health - General
33 Section 2-101 to be under the new part "Part I. General Provisions"
34 Annotated Code of Maryland
35 (1994 Replacement Volume and 1997 Supplement)

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

1 Section 2-105 and 2-106
2 Annotated Code of Maryland
3 (1994 Replacement Volume and 1997 Supplement)

4 BY adding to
5 Article - Health - General
6 Section 19-101 through 19-110 to be under the new part "Part I. State Health
7 Care Access and Systems Performance Commission" and the new subtitle
8 "Subtitle 1. Health Care Planning and Systems Regulation"; 19-112,
9 19-113, 19-129, and 19-133; and 19-303 and 19-304
10 Annotated Code of Maryland
11 (1996 Replacement Volume and 1997 Supplement)

12 BY repealing and reenacting, with amendments,
13 Article - Health - General
14 Section 19-111, 19-115, 19-117 through 19-121, 19-123 through 19-128,
15 19-134, 19-135, 19-137, 19-138, 19-139, 19-141, 19-143, and 19-145
16 through 19-149
17 Annotated Code of Maryland
18 (1996 Replacement Volume and 1997 Supplement)
19 (As enacted by Section 2 of this Act)

20 BY repealing and reenacting, without amendments,
21 Article - Health - General
22 Section 19-114, 19-116, 19-122, 19-130, 19-131, 19-132, 19-136, 19-140,
23 19-142, 19-144, 19-150, 19-151, and 19-152
24 Annotated Code of Maryland
25 (1996 Replacement Volume and 1997 Supplement)
26 (As enacted by Section 2 of this Act)

27 BY repealing and reenacting, with amendments,
28 Article - Health - General
29 Section 19-301, 19-307(a), 19-404, 19-406, 19-706(s), 19-906, 19-1601,
30 19-1602, 19-1603, 19-1604, and 19-1605
31 Annotated Code of Maryland
32 (1996 Replacement Volume and 1997 Supplement)

33 BY repealing and reenacting, with amendments,
34 Article - Insurance
35 Section 15-111
36 Annotated Code of Maryland
37 (1997 Volume)
38 (As enacted by Chapter 57 of the Acts of the General Assembly of 1997)

1 BY repealing and reenacting, with amendments,
2 Article - Insurance
3 Section 15-606, 15-1001, 15-1201(n), 15-1205(c), 15-1207, and 15-1214
4 Annotated Code of Maryland
5 (1997 Volume)

6 BY repealing and reenacting, with amendments,
7 Article - Insurance
8 Section 15-9A-01, 15-9A-03, 15-9A-04, 15-9A-05(a) and (b), 15-9A-06(a),
9 (e), and (g), 15-9A-07(a), 15-9A-09(e), 15-9A-10 through 15-9A-14,
10 15-9A-17(b), and 15-9A-18(a)
11 Annotated Code of Maryland
12 (1997 Volume)
13 (As enacted by Section 3 of this Act)

14 BY adding to
15 Article - State Government
16 Section 8-403(i)
17 Annotated Code of Maryland
18 (1995 Replacement Volume and 1997 Supplement)

19 BY repealing and reenacting, with amendments,
20 Article 43C - Maryland Health and Higher Educational Facilities Authority
21 Section 16A
22 Annotated Code of Maryland
23 (1994 Replacement Volume and 1997 Supplement)

24 Preamble

25 WHEREAS, Over the last 25 years, Maryland's health care regulatory system
26 has evolved incrementally to address differing issues at different times; and

27 WHEREAS, As a result, the health care regulatory system today in Maryland is
28 a highly complex structure that needs to be reevaluated, streamlined, and better
29 coordinated to reflect the changed health care environment; and

30 WHEREAS, The current health care regulatory system consists of five
31 independent entities: the State Health Resources Planning Commission, the Health
32 Services Cost Review Commission, the Health Care Access and Cost Commission, the
33 Department of Health and Mental Hygiene, and the Maryland Insurance
34 Administration; and

35 WHEREAS, As a result of being regulated by these five independent entities,
36 the health care regulatory system that has developed in Maryland is one that lacks
37 coordination, contains functions that are outdated in today's environment, and lacks a
38 focus on improving quality of care; and

1 WHEREAS, To address these problems, the current health care regulatory
2 system must be streamlined; and

3 WHEREAS, Under a streamlined health care regulatory system, a single State
4 health policy can be better articulated, coordinated, and implemented and will only
5 serve to benefit the citizens of Maryland; now, therefore,

6 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
7 MARYLAND, That Section(s) 19-102 through 19-109, 19-121, 19-122, and 19-126,
8 the part "Part I. Health Planning and Development", and the subtitle "Subtitle 1.
9 Comprehensive Health Planning"; 19-202 through 19-207.1, 19-208 and 19-222 and
10 the subtitle "Subtitle 2. Health Services Cost Review Commission"; 19-1502 through
11 19-1506, 19-1509 through 19-1512, and 19-1515 and the subtitle "Subtitle 15.
12 Maryland Health Care Access and Cost Commission"; and 19-1606 of Article - Health
13 - General of the Annotated Code of Maryland be repealed.

14 SECTION 2. AND BE IT FURTHER ENACTED, That Section(s) 19-125 and the
15 part "Part II. Deficiencies in Services and Facilities"; 19-101, 19-110 through
16 19-120, 19-123, 19-201, 19-209, 19-210, 19-207.3, 19-211 through 19-213, 19-216
17 through 19-219, 19-207.2, 19-220, 19-214, 19-215, 19-221, 19-1501, 19-1507,
18 19-1508, 19-1516, 19-1513, and 19-1514, respectively, of Article - Health - General
19 of the Annotated Code of Maryland be renumbered to be Section(s) 2-108 and the part
20 "Part II. Deficiencies in Services and Facilities"; 19-111, 19-114 through 19-126, and
21 19-127 to be under the new part "Part II. Health Planning and Development";
22 19-128, 19-130, 19-131, 19-132, 19-134 through 19-137, 19-138 through 19-141,
23 19-142, 19-143, 19-144, 19-145, and 19-146 to be under the new part "Part III.
24 Health Care Facility Rate Setting"; 19-147, 19-148, 19-149, 19-150, 19-151, and
25 19-152 to be under the new part "Part IV. Medical Care Data Collection", respectively.

26 SECTION 3. AND BE IT FURTHER ENACTED, That Section(s) 19-1301
27 through 19-1305, 19-1305.1, 19-1305.2, 19-1305.3, 19-1305.4, and 19-1306 through
28 19-1313 and the subtitle "Subtitle 13. Private Review Agents", respectively, of the
29 Article - Health - General of the Annotated Code of Maryland be transferred to be
30 Section(s) 15-9A-01 through 15-9A-18 and the subtitle "Subtitle 9A. Private Review
31 Agents", respectively, of Article - Insurance of the Annotated Code of Maryland.

32 SECTION 4. AND BE IT FURTHER ENACTED, That Section(s) 15-605(e) of
33 Article - Insurance of the Annotated Code of Maryland be repealed.

34 SECTION 5. AND BE IT FURTHER ENACTED, That Section(s) 8-403(i) of
35 Article - State Government of the Annotated Code of Maryland be repealed.

36 SECTION 6. AND BE IT FURTHER ENACTED, That the Laws of Maryland
37 read as follows:

1 **Article - Health - General**

2 SUBTITLE 3. MISCELLANEOUS PROVISIONS.

3 1-301.

4 (A) THE SECRETARY, THE INSURANCE COMMISSIONER, AND THE HEALTH
5 CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION SHALL COORDINATE
6 THEIR ACTIVITIES, DUTIES, AND RESPONSIBILITIES AS SPECIFIED IN THIS ARTICLE
7 AND THE INSURANCE ARTICLE TO THE EXTENT THEIR ACTIVITIES, DUTIES, AND
8 RESPONSIBILITIES OVERLAP OR MAY IMPACT EACH OTHER BY:

9 (1) CONDUCTING MEETINGS ON AT LEAST A QUARTERLY BASIS TO
10 DISCUSS COMMON ISSUES, PARTICULARLY THOSE ISSUES INVOLVING STATE
11 HEALTH POLICY, AND DETERMINE METHODS BY WHICH THEY CAN BETTER
12 COORDINATE IN ORDER TO RESOLVE OR HANDLE WITH THOSE COMMON ISSUES;

13 (2) SHARING COPIES OF ALL PUBLIC REPORTS, MINUTES FROM PUBLIC
14 MEETINGS OR HEARINGS, AND ANY DOCUMENTS OR LETTERS THAT MAY BE USEFUL
15 TO ONE OR MORE OF THE ENTITIES; AND

16 (3) COMMUNICATING IN AN OPEN AND FREQUENT MANNER BETWEEN
17 THE STAFF OF EACH ENTITY AT ANY TIME.

18 (B) THE SECRETARY, THE STATE INSURANCE COMMISSIONER, AND THE
19 HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION JOINTLY SHALL
20 DEVELOP A SINGLE POINT OF ENTRY SYSTEM FOR CONSUMER COMPLAINTS
21 REGARDING HEALTH PLANS AND HEALTH MAINTENANCE ORGANIZATIONS.

22 (C) (1) THE SECRETARY, THE STATE INSURANCE COMMISSIONER, AND THE
23 HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION JOINTLY SHALL
24 SUBMIT AN ANNUAL REPORT TO THE FOLLOWING:

25 (I) THE GOVERNOR; AND

26 (II) SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE,
27 THE GENERAL ASSEMBLY.

28 (2) THE REPORT SHALL DESCRIBE:

29 (I) SPECIFIC EFFORTS AND ACTIVITIES OF THE ENTITIES TO WORK
30 IN A COOPERATIVE AND COORDINATED MANNER; AND

31 (II) RECOMMENDATIONS FOR INITIATIVES THAT REQUIRE ACTION
32 BY THE EXECUTIVE OR LEGISLATIVE BRANCHES THAT ARE NECESSARY TO
33 IMPLEMENT AND FACILITATE THE COORDINATION OF THE ACTIVITIES AND DUTIES
34 OF THE ENTITIES.

1 PART I. GENERAL PROVISIONS.

2 2-101.

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

5 2-105.

6 (a) The Secretary shall establish general policy for, and adopt standards to
7 promote and guide the development of, the physical and mental hygiene services of
8 this State and its subdivisions.

9 (b) The Secretary is responsible for the health interests of the people of this
10 State and shall supervise generally the administration of the health laws of this State
11 and its subdivisions.

12 (C) AS PART OF THE SECRETARY'S RESPONSIBILITIES UNDER SUBSECTION (B)
13 OF THIS SECTION, FOR THE PURPOSE OF BETTER EVALUATING AND IMPROVING THE
14 QUALITY OF HEALTH CARE SERVICES BEING PROVIDED TO THE CITIZENS OF THIS
15 STATE, THE SECRETARY, IN COOPERATION WITH THE HEALTH CARE ACCESS AND
16 SYSTEMS PERFORMANCE COMMISSION, SHALL DEVELOP METHODOLOGIES TO
17 ASSESS HEALTH CARE TREATMENT OUTCOMES.

18 2-106.

19 (a) The following units are in the Department:

20 (1) Alcohol and Drug Abuse Administration.

21 (2) Anatomy Board.

22 (3) Developmental Disabilities Administration.

23 (4) [State Health Resources Planning Commission.

24 (5) Health Services Cost Review Commission.

25 (6)] Maryland Psychiatric Research Center.

26 [(7)] (5) Mental Hygiene Administration.

27 [(8)] (6) Postmortem Examiners Commission.

28 [(9)] (7) Board of Examiners for Audiologists.

29 [(10)] (8) Board of Chiropractic Examiners.

30 [(11)] (9) Board of Dental Examiners.

31 [(12)] (10) Board of Dietetic Practice.

1 [(13)] (11) Board of Electrologists.

2 [(14)] (12) Board of Morticians.

3 [(15)] (13) Board of Nursing.

4 [(16)] (14) Board of Examiners of Nursing Home Administrators.

5 [(17)] (15) Board of Occupational Therapy Practice.

6 [(18)] (16) Board of Examiners in Optometry.

7 [(19)] (17) Board of Pharmacy.

8 [(20)] (18) Board of Physical Therapy Examiners.

9 [(21)] (19) Board of Physician Quality Assurance.

10 [(22)] (20) Board of Podiatry Examiners.

11 [(23)] (21) Board of Examiners of Professional Counselors.

12 [(24)] (22) Board of Examiners of Psychologists.

13 [(25)] (23) Board of Social Work Examiners.

14 [(26)] (24) Board of Examiners for Speech-Language Pathologists.

15 [(27)] (25) Commission on Physical Fitness.

16 [(28) Advisory Board on Hospital Licensing.]

17 (26) QUALITY MANAGEMENT ADMINISTRATION.

18 [(29)] (27) State Advisory Council on Alcohol and Drug Abuse.

19 [(30)] (28) Advisory Council on Infant Mortality.

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

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

1 SUBTITLE 1. HEALTH CARE PLANNING AND SYSTEMS REGULATION.

2 PART I. STATE HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION.

3 19-101.

4 IN THIS SUBTITLE, "COMMISSION" MEANS THE STATE HEALTH CARE ACCESS
5 AND SYSTEMS PERFORMANCE COMMISSION.

6 19-102.

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

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

16 19-103.

17 (A) THERE IS A STATE HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE
18 COMMISSION.

19 (B) THE COMMISSION IS AN INDEPENDENT COMMISSION THAT FUNCTIONS IN
20 THE DEPARTMENT.

21 (C) THE PURPOSE OF THE COMMISSION IS TO:

22 (1) DEVELOP HEALTH CARE COST CONTAINMENT STRATEGIES TO HELP
23 PROVIDE ACCESS TO APPROPRIATE QUALITY HEALTH CARE SERVICES FOR ALL
24 MARYLANDERS;

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

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

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

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

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

3 (V) CONSIDERING THE PLANS AND PROGRAMS OF STATE AGENCIES
4 AND DEPARTMENTS AND ASSURING CONSISTENCY WITH POLICIES AND PRIORITIES
5 OF SUCH AGENCIES AND DEPARTMENTS IN PREPARATION OF THE STATE HEALTH
6 PLAN; AND

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

9 (3) FACILITATE THE PUBLIC DISCLOSURE OF MEDICAL CLAIMS DATA
10 FOR THE DEVELOPMENT OF PUBLIC POLICY;

11 (4) ENCOURAGE THE DEVELOPMENT OF CLINICAL RESOURCE
12 MANAGEMENT SYSTEMS TO PERMIT THE COMPARISON OF COSTS BETWEEN VARIOUS
13 TREATMENT SETTINGS AND THE AVAILABILITY OF INFORMATION TO CONSUMERS,
14 PROVIDERS, AND PURCHASERS OF HEALTH CARE SERVICES;

15 (5) ESTABLISH STANDARDS FOR THE OPERATION AND LICENSING OF
16 MEDICAL CARE ELECTRONIC CLAIMS CLEARINGHOUSES IN THE STATE; AND

17 (6) REDUCE THE COSTS OF CLAIMS SUBMISSION AND THE
18 ADMINISTRATION OF CLAIMS FOR HEALTH CARE PRACTITIONERS AND PAYORS.

19 19-104.

20 (A) THE COMMISSION SHALL CONSIST OF 11 MEMBERS APPOINTED BY THE
21 GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE.

22 (B) OF THE 11 MEMBERS:

23 (1) SIX SHALL BE APPOINTED WITH TWO INDIVIDUALS EACH FROM THE
24 MEMBERSHIP OF THE HEALTH RESOURCES PLANNING COMMISSION, THE HEALTH
25 SERVICES COST REVIEW COMMISSION, AND THE HEALTH CARE ACCESS AND COST
26 COMMISSION AS EACH COMMISSION EXISTED ON JUNE 30, 1998; AND

27 (2) FIVE SHALL BE INDIVIDUALS WHO DO NOT HAVE ANY CONNECTION
28 WITH THE MANAGEMENT OR POLICY OF A HEALTH CARE PROVIDER OR THIRD PARTY
29 PAYOR.

30 (C) TO THE EXTENT PRACTICABLE, WHEN APPOINTING MEMBERS TO THE
31 COMMISSION THE GOVERNOR SHALL ASSURE GEOGRAPHIC BALANCE IN THE
32 COMMISSION'S MEMBERSHIP.

33 (D) (1) THE TERM OF A MEMBER IS 4 YEARS.

34 (2) THE TERMS OF THE MEMBERS ARE STAGGERED AS REQUIRED BY
35 THE TERMS PROVIDED FOR MEMBERS OF THE COMMISSION ON JULY 1, 1998.

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

4 (4) THE GOVERNOR MAY REMOVE A MEMBER FOR NEGLECT OF DUTY,
5 INCOMPETENCE, OR MISCONDUCT.

6 (5) A MEMBER MAY NOT SERVE MORE THAN TWO CONSECUTIVE TERMS.

7 (E) (1) EACH MEMBER OF THE COMMISSION IS ENTITLED TO
8 REIMBURSEMENT IN ACCORDANCE WITH THE STATE BUDGET FOR CARRYING OUT
9 THEIR DUTIES AND RESPONSIBILITIES.

10 (2) A MEMBER OF THE COMMISSION MAY NOT HOLD ANY POSITION OR
11 ENGAGE IN OTHER BUSINESS THAT:

12 (I) INTERFERES WITH THE MEMBER'S APPOINTMENT TO THE
13 COMMISSION; OR

14 (II) MIGHT CONFLICT WITH OR HAVE THE APPEARANCE OF
15 CONFLICTING WITH THE MEMBER'S DUTIES AND RESPONSIBILITIES AS A MEMBER
16 OF THE COMMISSION.

17 19-105.

18 (A) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, THE GOVERNOR
19 SHALL APPOINT THE CHAIRMAN OF THE COMMISSION.

20 (2) IN APPOINTING THE INITIAL CHAIRMAN OF THE COMMISSION, THE
21 GOVERNOR MAY NOT SELECT A MEMBER APPOINTED IN ACCORDANCE WITH §
22 19-104(B)(1) OF THIS SUBTITLE.

23 (B) THE CHAIRMAN MAY APPOINT A VICE CHAIRMAN OF THE COMMISSION.

24 19-106.

25 (A) THE COMMISSION SHALL APPOINT AN EXECUTIVE DIRECTOR WHO SHALL
26 BE THE CHIEF ADMINISTRATIVE OFFICER OF THE COMMISSION.

27 (B) THE EXECUTIVE DIRECTOR SHALL:

28 (1) POSSESS A BROAD KNOWLEDGE OF GENERALLY ACCEPTED
29 PRACTICES IN THE DELIVERY OF HEALTH CARE SERVICES AND THE FINANCING OF
30 HEALTH CARE IN THE STATE; AND

31 (2) BE REASONABLY WELL INFORMED OF THE GENERAL LAWS AND
32 REGULATIONS THAT GOVERN ALL FACETS OF THE DELIVERY AND FINANCING OF
33 HEALTH CARE.

34 (C) (1) THE EXECUTIVE DIRECTOR SHALL DEVOTE FULL TIME TO THE
35 DUTIES OF THE OFFICE.

1 (2) THE EXECUTIVE DIRECTOR MAY NOT HOLD ANY POSITION OR
2 ENGAGE IN ANOTHER BUSINESS THAT:

3 (I) INTERFERES WITH THE POSITION OF EXECUTIVE DIRECTOR;
4 OR

5 (II) MIGHT CONFLICT OR HAVE THE APPEARANCE OF CONFLICTING
6 WITH THE POSITION OF EXECUTIVE DIRECTOR.

7 (D) THE EXECUTIVE DIRECTOR AND ANY DEPUTY DIRECTORS AND PRINCIPAL
8 SECTION CHIEFS SERVE AT THE PLEASURE OF THE COMMISSION.

9 (E) THE COMMISSION, IN CONSULTATION WITH THE SECRETARY, SHALL
10 DETERMINE THE APPROPRIATE JOB CLASSIFICATION AND, SUBJECT TO THE STATE
11 BUDGET, THE COMPENSATION FOR THE EXECUTIVE DIRECTOR, THE DEPUTY
12 DIRECTORS, AND THE PRINCIPAL SECTION CHIEFS.

13 (F) UNDER THE DIRECTION OF THE COMMISSION, THE EXECUTIVE DIRECTOR
14 SHALL PERFORM ANY DUTY OR FUNCTION THAT THE COMMISSION REQUIRES.

15 19-107.

16 (A) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A MAJORITY OF
17 THE FULL AUTHORIZED MEMBERSHIP OF THE COMMISSION IS A QUORUM.

18 (2) THE COMMISSION MAY NOT ACT ON ANY MATTER UNLESS AT LEAST
19 FOUR OF THE VOTING MEMBERS IN ATTENDANCE CONCUR.

20 (B) THE COMMISSION SHALL MEET AT THE TIMES AND PLACES THAT IT
21 DETERMINES ARE APPROPRIATE.

22 (C) EACH MEMBER OF THE COMMISSION IS ENTITLED TO REIMBURSEMENT
23 FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED
24 IN THE STATE BUDGET.

25 (D) THE COMMISSION MAY EMPLOY A STAFF IN ACCORDANCE WITH THE
26 STATE BUDGET.

27 19-108.

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

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

32 (2) CREATE COMMITTEES FROM AMONG ITS MEMBERS;

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

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

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

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

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

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

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

16 (2) KEEP MINUTES OF EACH MEETING;

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

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

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

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

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

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

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

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

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

8 19-109.

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

11 (2) "FUND" MEANS THE HEALTH CARE ACCESS AND SYSTEMS
12 PERFORMANCE FUND.

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

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

18 (5) "PAYOR" MEANS:

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

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

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

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

29 (1) ALL HOSPITALS SUBJECT TO A USER FEE ASSESSMENT BY THE
30 HEALTH SERVICES COST REVIEW COMMISSION ON JANUARY 1, 1998;

31 (2) ALL NURSING HOMES;

32 (3) ALL PAYORS; AND

33 (4) ALL HEALTH CARE PRACTITIONERS SUBJECT TO A USER FEE
34 ASSESSMENT BY THE HEALTH CARE ACCESS AND COST COMMISSION ON JANUARY 1,
35 1998.

1 (C) (1) THE TOTAL FEES ASSESSED BY THE COMMISSION MAY NOT EXCEED
2 $8,000,000 IN ANY FISCAL YEAR.

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

7 (3) THE COMMISSION SHALL PAY ALL FUNDS COLLECTED FROM THE
8 FEES ASSESSED IN ACCORDANCE WITH THIS SECTION INTO THE HEALTH CARE
9 ACCESS AND SYSTEMS PERFORMANCE COMMISSION FUND.

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

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

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

16 (I) HOSPITALS AND SPECIAL HOSPITALS FOR A TOTAL AMOUNT
17 NOT EXCEEDING $4,700,000 IN ANY FISCAL YEAR; AND

18 (II) NURSING HOMES FOR A TOTAL AMOUNT NOT EXCEEDING
19 $300,000 IN ANY FISCAL YEAR;

20 (2) SHALL ASSESS PAYORS FOR A TOTAL AMOUNT NOT EXCEEDING
21 $2,500,000 IN ANY FISCAL YEAR; AND

22 (3) SHALL ASSESS HEALTH CARE PRACTITIONERS FOR AN AMOUNT NOT
23 EXCEEDING $500,000 IN ANY FISCAL YEAR.

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

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

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

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

33 (F) (1) THERE IS A HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE
34 COMMISSION FUND.

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

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

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

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

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

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

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

14 (G) THE COMMISSION SHALL:

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

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

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

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

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

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

35 1. THE AMOUNT EQUAL TO ONE HALF OF THE TOTAL FEES
36 TO BE ASSESSED ON NURSING HOMES UNDER SUBSECTION (D)(1)(II) OF THIS

1 SECTION TIMES THE RATIO OF ADMISSIONS TO THE NURSING HOME TO TOTAL
2 ADMISSIONS OF ALL NURSING HOMES; AND

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

7 (III) ESTABLISH MINIMUM AND MAXIMUM ASSESSMENTS; AND

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

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

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

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

17 19-110.

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

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

27 PART II. HEALTH PLANNING AND DEVELOPMENT.

28 19-111.

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

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

34 (i) Has two or more operating rooms;

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

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

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

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

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

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

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

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

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

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

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

22 (iii) An ambulatory surgical facility;

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

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

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

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

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

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

1 (ii) For the purpose of providing an exemption from a certificate of
2 need under [§ 19-115] § 19-120 of this subtitle, a facility to provide comprehensive
3 care constructed by a provider of continuing care, as defined by Article 70B of the
4 Code, if:

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

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

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

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

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

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

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

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

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

31 19-112.

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

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

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

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

3 (II) DISTRIBUTION OF HEALTH CARE RESOURCES;

4 (III) ALLOCATION OF MANPOWER RESOURCES;

5 (IV) ALLOCATION OF HEALTH CARE RESOURCES;

6 (V) COSTS OF HEALTH CARE IN RELATIONSHIP TO AVAILABLE
7 FINANCIAL RESOURCES; OR

8 (VI) ANY OTHER APPROPRIATE MATTER.

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

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

16 19-113.

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

19 (2) THE STUDY SHALL:

20 (I) DETERMINE FOR HEALTH DELIVERY FACILITIES AND SETTINGS
21 WITH THE POTENTIAL TO SIGNIFICANTLY IMPACT THE HEALTH CARE SYSTEM IN
22 MARYLAND WHERE CAPACITY SHOULD BE INCREASED OR DECREASED TO BETTER
23 MEET THE NEEDS OF THE POPULATION;

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

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

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

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

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

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

3 (I) IMPOSE A PENALTY OF NOT MORE THAN $100 PER DAY FOR
4 EACH DAY THE VIOLATION CONTINUES AFTER CONSIDERATION OF THE
5 WILLFULNESS AND SERIOUSNESS OF THE WITHHOLDING AS WELL AS ANY PAST
6 HISTORY OF WITHHOLDING OF INFORMATION;

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

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

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

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

20 (2) THE COMMISSION SHALL:

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

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

28 19-114.

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

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

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

4 19-115.

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

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

10 (1) Full or conditional designation by the federal government by October
11 1, 1982;

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

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

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

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

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

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

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

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

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

34 (1) Use the population estimates that the Department prepares under §
35 4-218 of this article;

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

3 (3) Meet applicable planning specifications; and

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

6 (F) PRIOR TO THE ADOPTION OF A STATE HEALTH PLAN UNDER § 19-118 OF
7 THIS SUBTITLE, THE COMMISSION SHALL PROVIDE THE OPPORTUNITY FOR LOCAL
8 HEALTH PLANNING AGENCIES TO SUBMIT TO THE COMMISSION INFORMATION ON
9 LOCAL HEALTH NEEDS AND RESOURCES AS IDENTIFIED IN LOCAL HEALTH PLANS.

10 19-116.

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

15 19-117.

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

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

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

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

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

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

31 (1) Sue and be sued;

32 (2) Make contracts;

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

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

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

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

4 (7) Adopt bylaws to conduct its affairs; and

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

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

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

13 19-118.

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

16 (2) The plan shall include:

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

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

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

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

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

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

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

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

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

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

6 (2) The standards:

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

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

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

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

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

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

26 19-119.

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

29 (b) The institution-specific plan shall address:

30 (1) Accurate bed count data for licensed beds and staffed and operated
31 beds;

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

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

35 (4) Accessibility and availability of beds;

1 (5) Quality of care;

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

4 (7) Hospitals in high growth areas; and

5 (8) Utilization.

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

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

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

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

20 (4) A State health plan developed or adopted after the incorporation of
21 the institution-specific plan into the State health plan shall include the criteria in
22 subsection (b) of this section in addition to the criteria in [§ 19-114 of this article] §
23 19-118 OF THIS SUBTITLE.

24 19-120.

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

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

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

30 (3) "LIMITED SERVICE HOSPITAL" MEANS A HEALTH CARE FACILITY
31 THAT:

32 (I) IS LICENSED AS A HOSPITAL ON OR AFTER JANUARY 1, 1998;
33 AND

34 (II) CHANGES THE TYPE OR SCOPE OF HEALTH CARE SERVICES
35 OFFERED BY ELIMINATING THE FACILITY'S CAPABILITY TO ADMIT OR RETAIN
36 PATIENTS FOR OVERNIGHT ACUTE MEDICAL-SURGICAL CARE.

1 [(3)] (4) "Medical service" means:

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

3 1. Medicine, surgery, gynecology, addictions;

4 2. Obstetrics;

5 3. Pediatrics;

6 4. Psychiatry;

7 5. Rehabilitation;

8 6. Chronic care;

9 7. Comprehensive care;

10 8. Extended care;

11 9. Intermediate care; or

12 10. Residential treatment; or

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

16 (b) The Commission may set an application fee for a certificate of need for
17 HEALTH CARE facilities not assessed a user fee under [§ 19-122] § 19-109 of this
18 subtitle.

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

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

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

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

32 (2) A certificate of need issued prior to January 13, 1987 may not be
33 rendered wholly or partially invalid solely because certain conditions have been

1 imposed, if an appeal concerning the certificate of need, challenging the power of the
2 Commission to impose certain conditions on a certificate of need, has not been noted
3 by an aggrieved party before January 13, 1987.

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

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

9 (2) This subsection does not apply if:

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

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

16 (III) 1. THE RELOCATION IS TO:

17 A. ANOTHER AREA ON OR IMMEDIATELY ADJACENT TO THE
18 SITE OF THE EXISTING HOSPITAL OR RELATED INSTITUTION THAT IS A COMPONENT
19 OF A MERGED ASSET ORGANIZATION OF WHICH THE MOVED HEALTH CARE FACILITY
20 IS A COMPONENT; OR

21 B. A SITE WITHIN THE PRIMARY SERVICE AREA OF AN
22 EXISTING HEALTH CARE FACILITY OR MERGED ASSET ORGANIZATION'S PRIMARY
23 SERVICE AREA OF WHICH THE MOVED HEALTH CARE FACILITY IS COMPONENT; AND

24 2. AT LEAST 45 DAYS PRIOR TO THE RELOCATION, NOTICE OF
25 THE PROPOSED RELOCATION IS FILED WITH THE COMMISSION.

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

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

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

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

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

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

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

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

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

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

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

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

16 D. Is in the public interest.]

17 (III) THE CHANGE IN BED CAPACITY IS A RESULT OF A
18 CONSOLIDATION OR MERGER OF 2 OR MORE HEALTH CARE FACILITIES THAT ARE
19 COMPONENTS OF A MERGED ASSET ORGANIZATION WITHIN THE SAME HEALTH
20 PLANNING REGION AND, AT LEAST 45 DAYS BEFORE THE PROPOSED CHANGE IN BED
21 CAPACITY, NOTICE OF INTENT TO CHANGE BED CAPACITY IS FILED WITH THE
22 COMMISSION.

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

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

28 (i) By a health care facility;

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

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

31 (2) This subsection does not apply if:

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

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

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

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

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

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

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

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

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

18 A. Is pursuant to the consolidation or merger of 2 or more
19 health care facilities, [or] THE conversion of a health care facility or part of a facility
20 to a nonhealth-related use, OR THE CONVERSION OF A HOSPITAL TO A LIMITED
21 SERVICE HOSPITAL;

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

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

26 D. Is in the public interest; and

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

29 (V) THE PROPOSED CHANGE IN THE TYPE OR SCOPE OF A HEALTH
30 CARE SERVICE IS BETWEEN 1 OR MORE HEALTH CARE FACILITIES THAT ARE
31 COMPONENTS OF A MERGED ASSET ORGANIZATION WITH THE SAME HEALTH
32 PLANNING REGION AND NOTICE OF THE PROPOSED CHANGE IS FILED WITH THE
33 COMMISSION WITHIN 45 DAYS PRIOR TO THE CHANGE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (5) This subsection does not apply to:

26 (i) Site acquisition;

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

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

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

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

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

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

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

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

9 C. Is in the public interest; and

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

12 [(vi)] (V) A capital expenditure by a nursing home for equipment,
13 construction, or renovation that:

14 1. Is not directly related to patient care; and

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

17 [(vii)] (VI) A capital expenditure by a hospital, as defined in §
18 19-301 of this title, for equipment, construction, or renovation that:

19 1. Is not directly related to patient care; and

20 2. Does not increase patient charges or hospital rates;

21 [(viii)] (VII) A capital expenditure by a hospital as defined in §
22 19-301 of this title, for a project in excess of $1,250,000 for construction or renovation
23 that:

24 1. May be related to patient care;

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

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

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

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

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

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

16 (6) [Paragraph (5)(vi), (vii), (viii), and (ix)]PARAGRAPH (5)(V) THROUGH
17 (VIII) of this subsection may not be construed to permit a facility to offer a new health
18 care service for which a certificate of need is otherwise required.

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

24 (i) Has obtained a certificate of need;

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

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

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

34 (l) [A] (1) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION,
35 A certificate of need is not required to close any hospital or part of a hospital as
36 defined in § 19-301 of this title [if:

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

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

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

6 (2) AT LEAST 45 DAYS BEFORE THE CLOSING OR PARTIAL CLOSING, A
7 PERSON PROPOSING TO CLOSE ALL OR PART OF A HOSPITAL SHALL FILE NOTICE OF
8 THE PROPOSED CLOSING OR PARTIAL CLOSING WITH THE COMMISSION.

9 (3) WITHIN 30 DAYS AFTER RECEIPT OF THE NOTICE OF INTENT TO
10 CLOSE, THE COMMISSION, IN CONSULTATION WITH THE HOSPITAL, SHALL HOLD A
11 PUBLIC INFORMATIONAL HEARING IN THE COUNTY WHERE THE HOSPITAL IS
12 LOCATED.

13 (4) FOR A HOSPITAL THAT IS THE SOLE PROVIDER OF ACUTE CARE
14 SERVICES IN A COUNTY, CLOSURE OF THE HOSPITAL SHALL BE PERMITTED ONLY IF
15 THE COMMISSION FINDS THAT THE CLOSING:

16 (I) IS IN THE PUBLIC INTEREST; AND

17 (II) IS NOT INCONSISTENT WITH:

18 1. THE STATE HEALTH PLAN; OR

19 2. AN INSTITUTION-SPECIFIC PLAN DEVELOPED BY THE
20 COMMISSION UNDER § 19-119 OF THIS SUBTITLE.

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

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

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

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

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

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

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

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

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

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

9 (O) (1) SUBJECT TO THE PROVISIONS OF PARAGRAPH (2) OF THIS
10 SUBSECTION, BUT NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, A
11 CERTIFICATE OF NEED IS NOT REQUIRED FOR DEVELOPING, BUILDING,
12 ESTABLISHING, OR OPERATING A HOME HEALTH AGENCY OR HOSPICE PROGRAM OR
13 FOR ANY HEALTH CARE SERVICE THAT A HOME HEALTH AGENCY OR HOSPICE
14 FACILITY PROVIDES.

15 (2) A CERTIFICATE OF NEED IS REQUIRED FOR THE CONSTRUCTION OR
16 RENOVATION OF A FACILITY TO PROVIDE INPATIENT HOSPICE CARE.

17 19-121.

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

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

25 (i) A hospital, as defined in § 19-301 of this title, or an ambulatory
26 surgical facility or center, as defined in [§ 19-101(f)] § 19-111(E) of this subtitle; and

27 (ii) Any other health care project for which a certificate of need is
28 required under [§ 19-115] § 19-120 of this subtitle if that health care project is
29 planned for or used by any nonsubscribers of that health maintenance organization.

30 (2) Notwithstanding paragraph (1)(i) of this subsection, a health
31 maintenance organization or a health care facility that either controls, directly or
32 indirectly, or is controlled by a health maintenance organization is not required to
33 obtain a certificate of need before purchasing an existing ambulatory surgical facility
34 or center, as defined in [§ 19-101(f) of this title] § 19-111(E) OF THIS SUBTITLE.

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

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

4 (2) Is not inconsistent with those sections of the State health plan or
5 those sections of the institution-specific plan that govern hospitals, as defined in §
6 19-301 of this title, and ambulatory surgical facilities or centers, as defined in [§
7 19-101(f)] § 19-111(E) of this subtitle, or health care projects for which a certificate of
8 need is required under subsection (b)(1)(ii) of this section.

9 19-122.

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

12 19-123.

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

14 (1) Offers any health service:

15 (i) Through a health care facility;

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

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

18 (2) To provide those services, makes an expenditure, if a certificate of
19 need would be required under [§ 19-115(j)] § 19-120(J) of this subtitle for the
20 expenditure by or on behalf of a health care facility;

21 (3) Acquires medical equipment if a certificate of need would be required
22 under [§ 19-115(k)] § 19-120(K) of this subtitle for the acquisition by a health care
23 facility; or

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

26 19-124.

27 (a) If the Commission receives an application for a certificate of need for a
28 change in the bed capacity of a health care facility, as required under [§ 19-115] §
29 19-120 of this subtitle, or for a health care project that would create a new health care
30 service or abolish an existing health care service, the Commission shall give notice of
31 the filing by publication in the Maryland Register and give the following notice to:

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

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

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

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

5 (b) Failure to give notice [shall] MAY not adversely affect the application.

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

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

13 (3) Unless the Commission finds that the facility or service for which the
14 proposed expenditure is to be made is not needed or is not consistent with the State
15 health plan, the Commission shall approve an application for a certificate of need
16 required under [§ 19-115(j)] § 19-120(J) of this subtitle to the extent that the
17 expenditure is to be made to:

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

20 (ii) Comply with State licensing standards; or

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

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

26 [(1)] (2) [Seven] FIVE voting members of the Commission shall be a
27 quorum TO ACT UPON AN APPLICATION FOR A CERTIFICATE OF NEED.

28 [(2)] (3) After an application is filed, the staff of the Commission:

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

31 (ii) May request further information from the applicant.

32 [(3)] (4) The Commission may delegate to a reviewer the responsibility
33 for review of an application for a certificate of need, including:

34 (i) The holding of an evidentiary hearing if the Commission, in
35 accordance with criteria it has adopted by regulation, considers an evidentiary

1 hearing appropriate due to the magnitude of the impact the proposed project may
2 have on the health care delivery system; and

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

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

7 [(5)] (6) The Commission shall delegate to its staff the responsibility for
8 an initial review of an application, including, in the event that no written comments
9 on an application are submitted by any interested party other than the staff of the
10 Commission, the preparation of a recommended decision for consideration by the full
11 Commission.

12 [(6)] (7) Any "interested party" may submit written comments on the
13 application in accordance with procedural regulations adopted by the Commission.

14 [(7)] (8) The Commission shall define the term "interested party" to
15 include, at a minimum:

16 (i) The staff of the Commission;

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

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

20 [(8)] (9) The reviewer shall review the application, any written
21 comments on the application, and any other materials permitted by this section or by
22 the Commission's regulations, and present a recommended decision on the application
23 to the full Commission.

24 [(9)] (10) (i) An applicant and any interested party may request the
25 opportunity to present oral argument to the reviewer, in accordance with regulations
26 adopted by the Commission, before the reviewer prepares a recommended decision on
27 the application for consideration by the full Commission.

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

30 [(10)] (11) Any interested party who has submitted written comments
31 under paragraph [(6)] (7) of this subsection may submit written exceptions to the
32 proposed decision and make oral argument to the Commission, in accordance with
33 regulations adopted by the Commission, before the Commission takes final action on
34 the application.

35 [(11)] (12) The Commission shall, after determining that the
36 recommended decision is complete, vote to approve, approve with conditions, or deny

1 the application on the basis of the recommended decision, the record before the staff
2 or the reviewer, and exceptions and arguments, if any, before the Commission.

3 [(12)] (13) The decision of the Commission shall be by a majority of the
4 quorum present and voting, except that no project shall be approved without the
5 affirmative vote of at least two consumer members of the Commission.

6 (e) Where the State health plan identifies a need for additional hospital bed
7 capacity in a region or subregion, in a comparative review of 2 or more applicants for
8 hospital bed expansion projects, a certificate of need shall be granted to 1 or more
9 applicants in that region or subregion that:

10 (1) Have satisfactorily met all applicable standards;

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

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

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

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

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

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

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

34 (h) (1) The applicant or any aggrieved party, as defined in [§ 19-120(a)] §
35 19-126(A) of this subtitle, may petition the Commission within 15 days for a
36 reconsideration.

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

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

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

7 19-125.

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

11 19-126.

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

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

16 (ii) The Secretary.

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

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

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

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

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

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

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

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

1 19-127.

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

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

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

9 (3) Is in the public interest.]

10 (A) (1) NOTWITHSTANDING ANY OTHER PROVISION OF THIS PART II OF THIS
11 SUBTITLE, SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, APPROVAL BY THE
12 COMMISSION OF A MERGER OR CONSOLIDATION OF 2 OR MORE HOSPITALS IS NOT
13 REQUIRED.

14 (2) AT LEAST 45 DAYS PRIOR TO A MERGER OR CONSOLIDATION UNDER
15 PARAGRAPH (1) OF THIS SUBSECTION, NOTICE OF THE MERGER OR CONSOLIDATION
16 SHALL BE FILED WITH THE COMMISSION.

17 (b) Notwithstanding the fact that a merger or consolidation or the joint
18 ownership and operation of major medical equipment may limit free economic
19 competition, a hospital may engage in a merger or consolidation or the joint
20 ownership of major medical equipment [that has been approved by the Commission
21 under this section] FOR WHICH NOTICE WAS FILED IN ACCORDANCE WITH
22 SUBSECTION (A) OF THIS SECTION.

23 PART III. HEALTH CARE FACILITY RATE SETTING.

24 19-128.

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

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

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

29 (1) Any hospital; or

30 (2) Any related institution.

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

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

34 (ii) Emergency services;

1 (iii) Outpatient services provided at the hospital, AS DEFINED BY
2 THE COMMISSION BY REGULATION; and

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

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

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

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

11 (ii) An intermediate care facility -- mental retardation.

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

14 19-129.

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

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

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

24 (I) HEALTH CARE COSTS;

25 (II) THE FINANCIAL STATUS OF ANY FACILITY; OR

26 (III) ANY OTHER APPROPRIATE MATTER.

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

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

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

1 (C) EXCEPT FOR PRIVILEGED MEDICAL INFORMATION, THE COMMISSION
2 SHALL MAKE:

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

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

8 19-130.

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

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

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

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

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

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

22 19-131.

23 The Commission shall:

24 (1) Require each facility to disclose publicly:

25 (i) Its financial position; and

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

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

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

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

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

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

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

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

7 19-132.

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

11 (1) Reduce uncompensated care; and

12 (2) Assure the integrity of the payment system.

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

16 (1) Are in the public interest;

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

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

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

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

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

27 19-133.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 1. PROVIDED THROUGH THE GROUP; AND

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

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

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

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

15 (I) ANY CUTTING INSTRUMENT;

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

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

20 (B) TO ASSURE ACCESS TO MEDICALLY NECESSARY OUTPATIENT SURGICAL
21 SERVICES FOR INDIVIDUALS WITHOUT HEALTH INSURANCE, THE COMMISSION
22 SHALL ADOPT REGULATIONS ESTABLISHING A METHOD AND MECHANISM TO
23 FINANCE THE REASONABLE TOTAL COST OF UNCOMPENSATED CARE PERFORMED
24 OR PROVIDED BY THE AMBULATORY SURGICAL FACILITIES.

25 (C) (1) THE METHOD AND MECHANISM ADOPTED BY REGULATION UNDER
26 SUBSECTION (B) OF THIS SECTION SHALL:

27 (I) BE CONSISTENT WITH THE METHOD ADOPTED BY THE
28 COMMISSION UNDER § 19-132 OF THIS SUBTITLE; AND

29 (II) INCLUDE AN ASSESSMENT ON EACH AMBULATORY SURGICAL
30 FACILITY FOR REASONABLE UNCOMPENSATED CARE COSTS THAT IS EQUAL TO THE
31 AVERAGE DOLLAR AMOUNT INCLUDED IN HOSPITAL OUTPATIENT CHARGES FOR
32 SURGICAL SERVICES.

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

1 (D) THE FUNDS GENERATED THROUGH THE METHOD AND MECHANISM
2 ADOPTED BY REGULATION BY THE COMMISSION UNDER SUBSECTION (B) OF THIS
3 SECTION MAY BE USED ONLY TO FINANCE THE DELIVERY OF REASONABLE
4 UNCOMPENSATED CARE FOR OUTPATIENT SURGICAL PROCEDURES AND SERVICES
5 PERFORMED OR PROVIDED IN HOSPITAL-BASED AND AMBULATORY SURGICAL
6 FACILITIES.

7 19-134.

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

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

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

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

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

21 19-135.

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

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

26 (2) A statement of income and expenses; and

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

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

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

31 (ii) Conform to the uniform accounting and financial reporting
32 system adopted under § 19-134 OF this subtitle; and

33 (iii) Be certified as follows:

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

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

2 (2) If the Commission requires, responsible officials of a facility also
3 shall attest that, to the best of their knowledge and belief, the report has been
4 prepared in conformity with the uniform accounting and financial reporting system
5 adopted under § 19-134 OF this subtitle.

6 19-136.

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

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

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

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

18 (c) The provisions of this section do not apply to any financial transaction,
19 contract, or other agreement made by a facility with any issuer of tax exempt bonds,
20 including the Maryland Health and Higher Education Facilities Authority, the State,
21 or any county or municipal corporation of the State, if a notice of the proposed
22 issuance of revenue bonds that meets the requirements of § 147(f) of the Internal
23 Revenue Code has been published.

24 19-137.

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

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

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

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

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

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

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

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

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

5 19-138.

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

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

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

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

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

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

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

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

26 19-139.

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

30 (2) The information shall include:

31 (i) Necessary operating expenses;

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

34 (iii) Incurred interest charges; and

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

3 (b) (1) The Commission shall define, by [rule or] regulation, the types and
4 classes of charges that may not be changed, except as specified in [§ 19-219] § 19-141
5 of this subtitle.

6 (2) SUBJECT TO THE PROVISIONS OF THIS SUBSECTION, THE
7 COMMISSION SHALL ALLOW HOSPITALS TO CHARGE BELOW
8 COMMISSION-APPROVED RATES FOR HOSPITAL OUTPATIENT SURGICAL SERVICES
9 IF:

10 (I) THE COMMISSION CONTINUES TO SET THE MAXIMUM
11 ALLOWABLE RATES FOR THESE HOSPITAL OUTPATIENT SURGICAL SERVICES FOR
12 INDIVIDUALS WITHOUT HEALTH INSURANCE COVERAGE; AND

13 (II) THE REVENUE LOSSES, IF ANY, ASSOCIATED WITH A HOSPITAL
14 CHARGING BELOW COMMISSION-APPROVED RATES FOR HOSPITAL OUTPATIENT
15 SURGICAL SERVICES ARE NOT RECOGNIZED BY THE COMMISSION AS REASONABLE
16 COSTS FOR REIMBURSEMENT AND ARE NOT USED TO JUSTIFY A RATE INCREASE.

17 (3) TO ASSURE ACCESS TO MEDICALLY NECESSARY OUTPATIENT
18 SURGICAL SERVICES, THE COMMISSION SHALL REQUIRE HOSPITALS TO INCLUDE
19 REASONABLE UNCOMPENSATED CARE COSTS ASSOCIATED WITH PROVIDING
20 OUTPATIENT SURGICAL SERVICES TO UNINSURED INDIVIDUALS IN THE HOSPITAL'S
21 CHARGES FOR OUTPATIENT SURGICAL SERVICES.

22 (4) TO FACILITATE IMPLEMENTATION OF GRADUATE MEDICAL
23 EDUCATION POLICIES OF THE STATE, THE COMMISSION SHALL REQUIRE HOSPITALS
24 TO INCLUDE REASONABLE GRADUATE MEDICAL EDUCATION COSTS ASSOCIATED
25 WITH PROVIDING MEDICALLY NECESSARY OUTPATIENT SURGICAL SERVICES FOR
26 INDIVIDUALS WITHOUT HEALTH INSURANCE COVERAGE IN THE HOSPITAL'S
27 CHARGES FOR OUTPATIENT SURGICAL SERVICES.

28 (5) THE COMMISSION MAY PHASE-IN IMPLEMENTATION OF THE
29 PROVISIONS OF PARAGRAPH (2) OF THIS SUBSECTION ON A REGIONAL BASIS BASED
30 ON THE COMPETITION IN THE REGIONAL MARKET FOR OUTPATIENT SURGICAL
31 SERVICES.

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

34 (d) The Commission shall:

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

38 (2) Permit a proprietary profitmaking facility to charge reasonable rates
39 that:

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

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

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

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

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

17 19-140.

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

20 19-141.

21 (a) (1) A facility may not change any rate schedule or charge of any type or
22 class defined under [§ 19-217(b)] § 19-139(B) of this subtitle, unless the facility files
23 with the Commission a written notice of the proposed change that is supported by any
24 information that the facility considers appropriate.

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

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

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

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

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

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

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

4 (5) The Commission:

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

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

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

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

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

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

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

19 (2) Accept any benefits under that decision.

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

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

24 (i) Funds received because of the change; and

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

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

28 (i) To refund the funds with interest; or

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

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

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

5 (2) Notwithstanding any of the provisions in this section, on notification
6 of a merger or consolidation by 2 or more hospitals, the Commission shall review the
7 rates of those hospitals that are directly involved in the merger or consolidation in
8 accordance with the rate review and approval procedures provided in [§ 19-217] §
9 19-139 of this subtitle and the regulations of the Commission.

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

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

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

17 (iii) Any other closure costs as defined in ARTICLE 43C, § 16A [of
18 Article 43C] of the Code; or

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

21 19-142.

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

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

27 (2) Funding the Hospital Employees Retraining Fund.

28 19-143.

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

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

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

34 (i) A partnership;

35 (ii) A firm;

1 (iii) A corporation; or

2 (iv) Any other business entity.

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

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

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

12 (c) A report under this section shall be:

13 (1) Signed and verified; and

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

16 (d) A person [who] THAT willfully fails to file any report required by this
17 section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding
18 $500.

19 19-144.

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

22 (1) Hold a public hearing;

23 (2) Conduct an investigation;

24 (3) Require the filing of any information; or

25 (4) Subpoena any witness or evidence.

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

28 19-145.

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

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

3 (1) Provided by the facility; or

4 (2) Performed by:

5 (i) The staff of the Commission;

6 (ii) A third party for the Commission; or

7 (iii) The Legislative Auditor.

8 19-146.

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

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

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

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

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

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

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

27 PART IV. MEDICAL CARE DATA COLLECTION.

28 19-147.

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

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

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

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

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

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

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

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

15 3. [a] A related [institution] INSTITUTION, as defined in §
16 19-301(l) of this article[,];

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

19 5. [an] AN outpatient clinic[,]; and

20 6. [a] A medical laboratory.

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

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

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

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

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

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

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

1 (i) Ambulatory surgery;

2 (ii) Radiological or diagnostic imagery; or

3 (iii) Laboratory services.

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

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

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

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

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

15 19-148.

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

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

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

23 (i) The demographic characteristics of the patient;

24 (ii) The principal diagnosis;

25 (iii) The procedure performed;

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

27 (v) The charge for the procedure;

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

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

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

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

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

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

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

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

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

21 (e) Until the provisions of [§ 19-1508] § 19-149 of this subtitle are fully
22 implemented, where appropriate, the Commission may limit the data collection under
23 this section.

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

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

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

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

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

35 (2) Representatives of the Health Services Cost Review Commission and
36 the Health Resources Planning Commission to ensure that the medical care data base
37 is compatible with, may be merged with, and does not duplicate information collected

1 by the Health Services Cost Review Commission hospital discharge data base, or data
2 collected by the Health Resources Planning Commission as authorized in § 19-107 of
3 this title] TO ENSURE THAT THE MEDICAL CARE DATA BASE IS COMPATIBLE WITH,
4 MAY BE MERGED WITH, AND DOES NOT DUPLICATE INFORMATION COLLECTED BY
5 THE COMMISSION UNDER PARTS II AND III OF THIS SUBTITLE.

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

10 19-149.

11 (a) (1) In order to more efficiently establish a medical care data base under
12 [§ 19-1507] § 19-148 of this subtitle, the Commission shall establish standards for
13 the operation of one or more medical care electronic claims clearinghouses in
14 Maryland and may license those clearinghouses meeting those standards.

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

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

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

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

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

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

35 (b) The Commission may collect the medical care claims information
36 submitted to any licensed claims clearinghouse for use in the data base established
37 under [§ 19-1507] § 19-148 of this subtitle.

38 (c) (1) The Commission shall:

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

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

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

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

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

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

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

22 19-150.

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

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

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

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

1 19-151.

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

4 (1) Hold a public hearing;

5 (2) Conduct an investigation; or

6 (3) Require the filing of any reasonable information.

7 19-152.

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

13 Subtitle 3. Hospitals and Related Institutions.

14 19-301.

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

16 (b) "Accredited hospital" means a hospital accredited by the Joint Commission
17 on Accreditation of Healthcare Organizations.

18 (c) "Accredited residential treatment center" means a residential treatment
19 center that is accredited by the Joint Commission on Accreditation of Healthcare
20 Organizations.

21 (D) "ADMINISTRATION" MEANS THE QUALITY MANAGEMENT
22 ADMINISTRATION.

23 [(d)] (E) "Apartment unit" means any space, in a residential building, that is
24 enclosed and self-contained and has a sanitary environment, if the space includes:

25 (1) 2 or more rooms;

26 (2) A direct exit to a thoroughfare or to a common element leading to a
27 thoroughfare;

28 (3) Facilities for living, sleeping, and eating; and

29 (4) At least the following facilities for cooking:

30 (i) Storage space for food and utensils;

31 (ii) A refrigerator;

1 (iii) A cook top; and

2 (iv) Adequate electrical capacity and outlets for small appliances.

3 [(e)] (F) (1) "Domiciliary care" means services that are provided to aged or
4 disabled individuals in a protective, institutional or home-type environment.

5 (2) "Domiciliary care" includes:

6 (i) Shelter;

7 (ii) Housekeeping services;

8 (iii) Board;

9 (iv) Facilities and resources for daily living; and

10 (v) Personal surveillance or direction in the activities of daily
11 living.

12 [(f)] (G) "Hospital" means an institution that:

13 (1) Has a group of at least 5 physicians who are organized as a medical
14 staff for the institution;

15 (2) Maintains facilities to provide, under the supervision of the medical
16 staff, diagnostic and treatment services for 2 or more unrelated individuals; and

17 (3) Admits or retains the individuals for overnight care.

18 [(g)] (H) "License" means a license issued by the Secretary:

19 (1) To operate a hospital in this State;

20 (2) To operate a related institution in this State; or

21 (3) To operate a residential treatment center in this State.

22 (I) "LIMITED SERVICE HOSPITAL" MEANS A HEALTH CARE FACILITY THAT:

23 (1) IS LICENSED AS A HOSPITAL ON OR AFTER JANUARY 1, 1998; AND

24 (2) CHANGES THE TYPE OR SCOPE OF HEALTH CARE SERVICES
25 OFFERED BY ELIMINATING THE FACILITY'S CAPABILITY TO ADMIT OR RETAIN
26 PATIENTS FOR OVERNIGHT ACUTE MEDICAL-SURGICAL CARE.

27 [(h)] (J) "Nonaccredited hospital" means a hospital not accredited by the Joint
28 Commission on Accreditation of Healthcare Organizations.

1 [(i)] (K) "Nonaccredited residential treatment center" means a residential
2 treatment center that is not accredited by the Joint Commission on Accreditation of
3 Healthcare Organizations.

4 [(j)] (L) "Nursing care" means service for a patient that is:

5 (1) Ordered by a physician; and

6 (2) Provided or supervised by a registered or practical nurse who is
7 licensed to practice in this State.

8 [(k)] (M) "Nursing facility" means a related institution that provides nursing
9 care for 2 or more unrelated individuals.

10 [(l)] (N) "Person" includes this State or a county or municipal corporation.

11 [(m)] (O) (1) "Personal care" means a service that an individual normally
12 would perform personally, but for which the individual needs help from another
13 because of advanced age, infirmity, or physical or mental limitation.

14 (2) "Personal care" includes:

15 (i) Help in walking;

16 (ii) Help in getting in and out of bed;

17 (iii) Help in bathing;

18 (iv) Help in dressing;

19 (v) Help in feeding; and

20 (vi) General supervision and help in daily living.

21 [(n)] (P) (1) "Related institution" means an organized institution,
22 environment, or home that:

23 (i) Maintains conditions or facilities and equipment to provide
24 domiciliary, personal, or nursing care for 2 or more unrelated individuals who are
25 dependent on the administrator, operator, or proprietor for nursing care or the
26 subsistence of daily living in a safe, sanitary, and healthful environment; and

27 (ii) Admits or retains the individuals for overnight care.

28 (2) "Related institution" does not include a nursing facility or visiting
29 nurse service that is conducted only by or for adherents of a bona fide church or
30 religious organization, in accordance with tenets and practices that include reliance
31 on treatment by spiritual means alone for healing.

32 [(o)] (Q) "Residential treatment center" means a psychiatric institution that
33 provides campus-based intensive and extensive evaluation and treatment of children

1 and adolescents with severe and chronic emotional disturbances who require a
2 self-contained therapeutic, educational, and recreational program in a residential
3 setting.

4 [(p)] (R) "Unrelated individual" means anyone who is not:

5 (1) A child, grandchild, parent, grandparent, sibling, stepparent,
6 stepchild, or spouse of the proprietor; or

7 (2) An in-law of any of these individuals.

8 19-303.

9 (A) THERE IS A QUALITY MANAGEMENT ADMINISTRATION IN THE
10 DEPARTMENT.

11 (B) THE ADMINISTRATION SHALL HAVE THE POWERS, DUTIES, AND
12 RESPONSIBILITIES AS PROVIDED IN THIS SUBTITLE AND AS MAY BE SPECIFIED
13 ELSEWHERE IN THIS TITLE.

14 19-304.

15 THE ADMINISTRATION SHALL:

16 (1) BE RESPONSIBLE FOR:

17 (I) LICENSING HOSPITALS AND RELATED INSTITUTIONS AS
18 PROVIDED IN PART III OF THIS SUBTITLE AND ANY OTHER HEALTH CARE FACILITIES
19 AND PROGRAMS OVER WHICH THE DEPARTMENT HAS LICENSING OR OTHER
20 REGULATORY AUTHORITY UNDER THIS ARTICLE;

21 (II) INVESTIGATING AND RESOLVING COMPLAINTS INVOLVING
22 HOSPITALS AND RELATED INSTITUTIONS AND ANY OTHER HEALTH CARE FACILITIES
23 AND PROGRAMS OVER WHICH THE DEPARTMENT HAS LICENSING OR OTHER
24 REGULATORY AUTHORITY UNDER THIS ARTICLE;

25 (III) INVESTIGATING AND RESOLVING COMPLAINTS INVOLVING
26 HEALTH MAINTENANCE ORGANIZATIONS, AS PROVIDED IN SUBTITLE 7 OF THIS
27 TITLE;

28 (IV) INSPECTING HOSPITALS AND RELATED INSTITUTIONS AND ANY
29 OTHER HEALTH CARE FACILITIES AND PROGRAMS OVER WHICH THE DEPARTMENT
30 HAS LICENSING OR OTHER REGULATORY AUTHORITY UNDER THIS ARTICLE TO
31 ENSURE THE QUALITY OF HEALTH CARE SERVICES BEING PROVIDED; AND

32 (V) MONITORING THE COMPLIANCE OF HOSPITALS AND RELATED
33 INSTITUTIONS AND ANY OTHER HEALTH CARE FACILITIES AND PROGRAMS OVER
34 WHICH THE DEPARTMENT HAS LICENSING OR OTHER REGULATORY AUTHORITY
35 UNDER THIS ARTICLE WITH BOTH STATE AND FEDERAL LAWS AND REGULATIONS

1 AND INITIATING ADMINISTRATIVE ACTION AGAINST HOSPITALS AND RELATED
2 INSTITUTIONS THAT VIOLATE STATE LAWS AND REGULATIONS;

3 (2) FACILITATE THE DISSEMINATION OF PRACTICE PARAMETERS AS
4 PROVIDED IN SUBTITLE 16 OF THIS TITLE;

5 (3) DEVELOP METHODOLOGIES TO ASSESS HEALTH CARE TREATMENT
6 OUTCOMES FOR THE PURPOSE OF BETTER EVALUATING THE QUALITY OF HEALTH
7 CARE SERVICES BEING PROVIDED TO THE CITIZENS OF THIS STATE;

8 (4) WORK COOPERATIVELY AND COORDINATE WITH OTHER STATE
9 AGENCIES AND ADVISORY BODIES IN CARRYING OUT THE PROVISIONS OF THIS
10 SUBTITLE; AND

11 (5) DO ANYTHING NECESSARY OR PROPER TO CARRY OUT THE SCOPE OF
12 THIS SUBTITLE.

13 19-307.

14 (a) (1) A hospital shall be classified:

15 (i) As a general hospital if the hospital at least has the facilities
16 and provides the services that are necessary for the general medical and surgical care
17 of patients;

18 (ii) As a special hospital if the hospital:

19 1. Defines a program of specialized services, such as
20 obstetrics, mental health, tuberculosis, orthopedy, chronic disease, or communicable
21 disease;

22 2. Admits only patients with medical or surgical needs
23 within the program; and

24 3. Has the facilities for and provides those specialized
25 services; [or]

26 (iii) As a special rehabilitation hospital if the hospital meets the
27 requirements of this subtitle and Subtitle 12 of this title; OR

28 (IV) AS A LIMITED SERVICE HOSPITAL IF THE HEALTH CARE
29 FACILITY:

30 1. IS LICENSED AS A HOSPITAL ON OR AFTER JANUARY 1,
31 1998; AND

32 2. CHANGES THE TYPE OR SCOPE OF HEALTH CARE
33 SERVICES OFFERED BY ELIMINATING THE FACILITY'S CAPABILITY TO ADMIT OR
34 RETAIN PATIENTS FOR OVERNIGHT ACUTE MEDICAL-SURGICAL CARE.

1 (2) The Secretary may set, by rule or regulation, other reasonable
2 classifications for hospitals.

3 Subtitle 4. Home Health Agencies.

4 19-404.

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

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

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

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

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

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

18 (5) Establish patient care policies and personnel policies;

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

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

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

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

29 (i) A licensed physician;

30 (ii) A registered nurse; or

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

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

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

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

4 (i) 1 physician;

5 (ii) 1 registered nurse;

6 (iii) 1 representative of another offered service; and

7 (iv) 1 public member;

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

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

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

12 (i) A physician;

13 (ii) A registered nurse; or

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

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

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

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

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

24 (3) The Secretary may:

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

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

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

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

3 19-406.

4 To qualify for a license, an applicant shall[:

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

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

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

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

12 Subtitle 7. Health Maintenance Organizations.

13 19-706.

14 (s) The provisions of Title 15, Subtitles 13 [and 14], 14, AND 15 of the
15 Insurance Article apply to health maintenance organizations.

16 Subtitle 9. Hospice Care Facilities.

17 19-906.

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

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

22 (1) At least 18 years old; and

23 (2) Of reputable and responsible character.

24 (c) (1) Except for a limited licensee, the applicant shall have a certificate of
25 need, as required under Subtitle 1 of this title, for [the] A NEW hospice care
26 [program] FACILITY to be [operated] CONSTRUCTED.

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

29 Subtitle 16. Advisory Committee on Practice Parameters.

30 19-1601.

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

1 (b) "Advisory Committee" means the Advisory Committee on Practice
2 Parameters in the Department.

3 (C) "HEALTH CARE PRACTITIONER" MEANS ANY INDIVIDUAL WHO PROVIDES
4 HEALTH CARE SERVICES AND IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED
5 UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE IN THE COURSE OF
6 PRACTICING A HEALTH CARE PROFESSION.

7 [(c)] (D) "Medical specialty" means any medical specialty designated by the
8 [Commission] SECRETARY.

9 19-1602.

10 (a) There is an Advisory Committee on Practice Parameters IN THE
11 DEPARTMENT.

12 (b) The purpose of the Advisory Committee is to [study the development of
13 practice parameters for medical specialties and to provide information for and make
14 recommendations to the Commission, including recommendations on the adoption
15 and use of practice parameters] DISSEMINATE TO AND EDUCATE HEALTH CARE
16 PRACTITIONERS ON PRACTICE PARAMETERS ON BEST PRACTICES FOR THE PURPOSE
17 OF IMPROVING THE QUALITY OF HEALTH CARE SERVICES DELIVERED TO THE
18 CITIZENS OF THIS STATE.

19 19-1603.

20 (a) (1) The Advisory Committee shall consist of 15 members appointed by
21 the Governor.

22 (2) Of the 15 members:

23 (i) Three shall be licensed Maryland physicians;

24 (ii) One shall represent medical liability insurers;

25 (iii) One shall represent health insurers;

26 (iv) One shall represent a member of the Maryland Bar specializing
27 in plaintiff medical malpractice cases;

28 (v) One shall represent a member of the Maryland Bar specializing
29 in defense of medical malpractice cases;

30 (vi) One shall represent hospitals;

31 (vii) One shall represent the QUALITY MANAGEMENT
32 ADMINISTRATION IN THE Department of Health and Mental Hygiene;

33 (viii) One shall be the dean, or the designee of the dean, of the Johns
34 Hopkins Medical School;

1 (ix) One shall be the dean, or the designee of the dean, of the
2 University of Maryland School of Medicine;

3 (x) One shall represent the Board of Physician Quality Assurance;
4 and

5 (xi) Three shall be public members.

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

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

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

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

12 (c) All members of the Advisory Committee shall be subject to all applicable
13 requirements of the Maryland Public Ethics Law.

14 19-1604.

15 (a) The Governor shall appoint a chairman of the Advisory Committee.

16 (b) The Advisory Committee shall determine the times and places of its
17 meetings.

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

21 (d) Staff for the Advisory Committee shall be provided by the [Commission, in
22 accordance with its budget] DEPARTMENT.

23 19-1605.

24 [On request of the Commission, the] THE Advisory Committee shall advise,
25 consult with, and propose to the [Commission] SECRETARY THE DISSEMINATION OF
26 practice parameters ON BEST PRACTICES for any MEDICAL specialty [designated by
27 the Commission] THAT THE COMMITTEE CONSIDERS APPROPRIATE that:

28 (1) Define appropriate clinical indications and methods of treatment for
29 individual procedures or diseases that are subject to a significant amount of medical
30 malpractice litigation within the medical specialty area;

31 (2) Are consistent with the appropriate standards of care;

32 (3) Are designed to discourage inappropriate utilization; and

1 (4) Are not inconsistent with certification, licensure, or accreditation
2 standards established by governmental agencies or national accreditation
3 organizations, including the Joint Commission on the Accreditation of Health Care
4 Organizations.

5 **Article - Insurance**

6 Subtitle 1. General Provisions.

7 15-111.

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

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

11 (3) "Payor" means:

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

15 (ii) a health maintenance organization that is licensed to operate in
16 the State; or

17 (iii) a third party administrator or any other entity under contract
18 with a Maryland business to administer health care benefits.

19 (b) (1) On or before June 30 of each year, the Commissioner shall assess
20 each payor a fee for the next fiscal year.

21 (2) The fee shall be established in accordance with this section and [§
22 19-1515] § 19-109 of the Health - General Article.

23 (c) (1) For each fiscal year, the total assessment for all payors shall be:

24 (i) set by a memorandum from the [Maryland Health Care Access
25 and Cost Commission] STATE HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE
26 COMMISSION; and

27 (ii) apportioned equitably by the Commissioner among the classes
28 of payors described in subsection (a)(3) of this section as determined by the
29 Commissioner.

30 (2) Of the total assessment apportioned under paragraph (1) of this
31 subsection to payors described in subsection (a)(3)(i) of this section, the Commissioner
32 shall assess each payor a fraction:

1 (i) the numerator of which is the payor's total premiums collected
2 in the State for health benefit plans for an appropriate prior 12-month period as
3 determined by the Commissioner; and

4 (ii) the denominator of which is the total premiums collected in the
5 State for the same period for health benefit plans of all payors described in subsection
6 (a)(3)(i) of this section.

7 (3) Of the total assessment apportioned under paragraph (1) of this
8 subsection to payors described in subsection (a)(3)(ii) of this section, the
9 Commissioner shall assess each payor a fraction:

10 (i) the numerator of which is the payor's total administrative fees
11 collected in the State for health benefit plans for an appropriate prior 12-month
12 period as determined by the Commissioner; and

13 (ii) the denominator of which is the total administrative fees
14 collected in the State for health benefit plans for the same period of all payors
15 described in subsection (a)(3)(ii) of this section.

16 (d) (1) Subject to paragraph (2) of this subsection, each payor that is
17 assessed a fee under this section shall pay the fee to the Commissioner on or before
18 September 1 of each year.

19 (2) The Commissioner, in cooperation with the [Maryland Health Care
20 Access and Cost Commission] STATE HEALTH CARE ACCESS AND SYSTEMS
21 PERFORMANCE COMMISSION, may provide for partial payments.

22 (e) The Commissioner shall distribute the fees collected under this section to
23 the [Health Care Access and Cost Fund] HEALTH CARE ACCESS AND SYSTEMS
24 PERFORMANCE COMMISSION FUND established under [§ 19-1515] § 19-109 of the
25 Health - General Article.

26 (f) Each payor shall cooperate fully in submitting reports and claims data and
27 providing any other information to the [Maryland Health Care Access and Cost
28 Commission in accordance with Title 19, Subtitle 15 of the Health - General Article]
29 STATE HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION IN
30 ACCORDANCE WITH TITLE 19, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

31 [(g) Each payor shall pay for health care services in accordance with the
32 payment system adopted under § 19-1509 of the Health - General Article.]

33 Subtitle 6. Required Reimbursement of Institutions.

34 15-606.

35 (a) In this section, "carrier" means:

36 (1) an insurer;

1 (2) a nonprofit health service plan;

2 (3) a health maintenance organization;

3 (4) a dental plan organization; or

4 (5) any other person that provides health benefit plans subject to
5 regulation by the State.

6 (b) [(1)] The [Health Care Access and Cost Commission] COMMISSIONER
7 shall adopt regulations that specify a plan for substantial, available, and affordable
8 coverage, that shall be offered in the nongroup market by a carrier that qualifies for
9 an approved purchaser differential under regulations adopted by the [Health
10 Services Cost Review Commission] HEALTH CARE ACCESS AND SYSTEMS
11 PERFORMANCE COMMISSION.

12 (C) [(2)] (1) In [establishing] DEVELOPING a plan under this subsection,
13 the [Health Care Access and Cost Commission]COMMISSIONER, IN CONSULTATION
14 WITH THE HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION, shall
15 judge preventive services, medical treatments, procedures, and related health
16 services based on:

17 (i) their effectiveness in improving the health of individuals;

18 (ii) their impact on maintaining and improving health and
19 encouraging consumers to use only the health care services they need; and

20 (iii) their impact on the affordability of health care coverage.

21 [(3)] (2) The [Health Care Access and Cost
22 Commission]COMMISSIONER may exclude from the plan:

23 (i) a health care service, benefit, coverage, or reimbursement for
24 covered health care services that is required under this article or the Health -
25 General Article to be provided or offered in a health benefit plan that is issued or
26 delivered in the State by a carrier; or

27 (ii) reimbursement required by statute, by a health benefit plan for
28 a service when that service is performed by a health care provider who is licensed
29 under the Health Occupations Article and whose scope of practice includes that
30 service.

31 [(4)] (3) The plan shall include uniform deductibles and cost-sharing
32 associated with its benefits, as determined by the [Health Care Access and Cost
33 Commission]COMMISSIONER.

34 [(5)] (4) In establishing cost-sharing as part of the plan, the [Health
35 Care Access and Cost Commission]COMMISSIONER shall:

1 (i) include cost-sharing and other incentives to help consumers
2 use only the health care services they need;

3 (ii) balance the effect of cost-sharing in reducing premiums and in
4 affecting utilization of appropriate services; and

5 (iii) limit the total cost-sharing that may be incurred by an
6 individual in a year.

7 (D) AFTER A PLAN IS DEVELOPED UNDER SUBSECTION (C) OF THIS SECTION,
8 EACH YEAR, THE COMMISSIONER SHALL REVIEW THE PLAN, IN CONSULTATION WITH
9 THE HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION, AND MAY
10 ADOPT BY REGULATION ANY CHANGES TO THE PLAN, AS PROVIDED IN SUBSECTION
11 (B) OF THIS SECTION.

12 Subtitle 9A. Private Review Agents.

13 15-9A-01.

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

15 (b) (1) "Adverse decision" means a utilization review determination made by
16 a private review agent that a proposed or delivered health care service:

17 (i) Is or was not necessary, appropriate, or efficient; and

18 (ii) May result in noncoverage of the health care service.

19 (2) There is no adverse decision if the private review agent and the
20 health care provider on behalf of the patient reach an agreement on the proposed or
21 delivered health care services.

22 (C) "CERTIFICATE" MEANS A CERTIFICATE OF REGISTRATION GRANTED BY
23 THE COMMISSIONER TO A PRIVATE REVIEW AGENT.

24 [(c)] (D) (1) "Employee assistance program" means a health care service
25 plan that, in accordance with a contract with an employer or labor union:

26 (i) Consults with employees or members of an employee's family or
27 both to:

28 1. Identify the employee's or the employee's family member's
29 mental health, alcohol, or substance abuse problems; and

30 2. Refer the employee or the employee's family member to
31 health care providers or other community resources for counseling, therapy, or
32 treatment; and

1 (ii) Performs utilization review for the purpose of making claims or
2 payment decisions on behalf of the employer's or labor union's health insurance or
3 health benefit plan.

4 (2) "Employee assistance program" does not include a health care service
5 plan operated by a hospital solely for employees, or members of an employee's family,
6 of that hospital.

7 [(d)] (E) "Health care facility" means:

8 (1) A hospital as defined in § 19-301 of [this title] THE HEALTH -
9 GENERAL ARTICLE;

10 (2) A related institution as defined in § 19-301 of [this title] THE
11 HEALTH - GENERAL ARTICLE;

12 (3) An ambulatory surgical facility or center which is any entity or part
13 thereof that operates primarily for the purpose of providing surgical services to
14 patients not requiring hospitalization and seeks reimbursement from third party
15 payors as an ambulatory surgical facility or center;

16 (4) A facility that is organized primarily to help in the rehabilitation of
17 disabled individuals;

18 (5) A home health agency as defined in § 19-401 of [this title] THE
19 HEALTH - GENERAL ARTICLE;

20 (6) A hospice as defined in § 19-901 of [this title] THE HEALTH -
21 GENERAL ARTICLE;

22 (7) A facility that provides radiological or other diagnostic imagery
23 services;

24 (8) A medical laboratory as defined in § 17-201 of [this article] THE
25 HEALTH - GENERAL ARTICLE; or

26 (9) An alcohol abuse and drug abuse treatment program as defined in §
27 8-403 of [this article] THE HEALTH - GENERAL ARTICLE.

28 (F) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL PROCEDURE
29 OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

30 (1) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN
31 DISEASE OR DYSFUNCTION; OR

32 (2) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR
33 MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

34 [(e) "Utilization review" means a system for reviewing the appropriate and
35 efficient allocation of hospital resources and services given or proposed to be given to
36 a patient or group of patients.]

1 [(f)] (G) "Private review agent" means:

2 (1) A nonhospital-affiliated person or entity performing utilization
3 review that is either affiliated with, under contract with, or acting on behalf of:

4 (i) A Maryland business entity; or

5 (ii) A third party that provides or administers hospital,
6 OUTPATIENT, MEDICAL, OR OTHER benefits to citizens of this State, including:

7 1. A health maintenance organization issued a certificate of
8 authority in accordance with TITLE 19, Subtitle 7 of [this title] THE HEALTH -
9 GENERAL ARTICLE; or

10 2. A health insurer, nonprofit health service plan, health
11 insurance service organization, or preferred provider organization authorized to offer
12 health insurance policies or contracts in this State in accordance with the [Insurance
13 Article] THIS ARTICLE; or

14 (2) Any person or entity including a hospital-affiliated person
15 performing utilization review for the purpose of making claims or payment decisions
16 on behalf of the employer's or labor union's health insurance plan under an employee
17 assistance program for employees other than the employees:

18 (i) Employed by the hospital; or

19 (ii) Employed by a business wholly owned by the hospital.

20 [(g)] (H) "Significant beneficial interest" means the ownership of any financial
21 interest that is greater than the lesser of:

22 (1) 5 percent of the whole; or

23 (2) $5,000.

24 (I) "UTILIZATION REVIEW" MEANS A SYSTEM FOR RETROSPECTIVE,
25 PROSPECTIVE, OR CONCURRENT REVIEW OF THE MEDICAL NECESSITY AND
26 APPROPRIATENESS OF HEALTH CARE SERVICES GIVEN OR PROPOSED TO BE GIVEN
27 TO A PATIENT OR GROUP OF PATIENTS.

28 [(h)] (J) "Utilization review plan" means a description of the standards
29 governing utilization review activities performed by a private review agent.

30 [(i) "Secretary" means the Secretary of Health and Mental Hygiene.

31 (j) "Commissioner" means the Insurance Commissioner.

32 (k) "Certificate" means a certificate of registration granted by the Secretary to
33 a private review agent.]

1 15-9A-03.

2 (a) A private review agent may not conduct utilization review in this State
3 unless the [Secretary] COMMISSIONER has granted the private review agent a
4 certificate.

5 (b) The [Secretary] COMMISSIONER shall issue a certificate to an applicant
6 that has met all the requirements of this subtitle and all applicable regulations of the
7 [Secretary] COMMISSIONER.

8 [(c) The Secretary may delegate the authority to issue a certificate to the
9 Commissioner for any health insurer or nonprofit health service plan regulated under
10 the Insurance Article or health maintenance organization issued a certificate of
11 authority in accordance with Subtitle 7 of this title that meets the requirements of
12 this subtitle and all applicable regulations of the Secretary.]

13 [(d)] (C) A certificate issued under this subtitle is not transferable.

14 [(e)] (D) (1) The [Secretary] COMMISSIONER, after consultation with [the
15 Commissioner,] payors, including the Health Insurance Association of America and
16 the Maryland Association of Health Maintenance Organizations, and providers of
17 health care, including the Maryland Hospital Association, the Medical and
18 Chirurgical Faculty of Maryland, and licensed or certified providers of treatment for
19 a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder, shall
20 adopt regulations to implement the provisions of this subtitle.

21 (2) (i) Subject to the provisions of subparagraph (iii) of this paragraph,
22 the regulations adopted by the [Secretary] COMMISSIONER shall include a uniform
23 treatment plan form for utilization review of services for the treatment of a mental
24 illness, emotional disorder, or a drug abuse or alcohol abuse disorder.

25 (ii) The uniform treatment plan form adopted by the [Secretary]
26 COMMISSIONER:

27 1. Shall adequately protect the confidentiality of the patient;
28 and

29 2. May only request the patient's membership number, policy
30 number, or other similar unique patient identifier and first name for patient
31 identification.

32 (iii) The [Secretary] COMMISSIONER may waive the requirements
33 of regulations adopted under subparagraph (i) of this paragraph for the use of a
34 uniform treatment plan form for any entity that would be using the form solely for
35 internal purposes.

36 15-9A-04.

37 (a) An applicant for a certificate shall:

1 (1) Submit an application to the [Secretary] COMMISSIONER; and

2 (2) Pay to the [Secretary] COMMISSIONER the application fee
3 established by the [Secretary] COMMISSIONER through regulation.

4 (b) The application shall:

5 (1) Be on a form and accompanied by any supporting documentation that
6 the [Secretary] COMMISSIONER requires; and

7 (2) Be signed and verified by the applicant.

8 (c) The application fees required under subsection (a)(2) of this section or [§
9 19-1306(b)(2)] § 15-9A-10(B)(2) of this subtitle shall be sufficient to pay for the
10 administrative costs of the certificate program and any other costs associated with
11 carrying out the provisions of this subtitle.

12 15-9A-05.

13 (a) In conjunction with the application, the private review agent shall submit
14 information that the [Secretary] COMMISSIONER requires including:

15 (1) A utilization review plan that includes:

16 (i) The specific criteria and standards to be used in conducting
17 utilization review of proposed or delivered services;

18 (ii) Those circumstances, if any, under which utilization review may
19 be delegated to a hospital utilization review program; and

20 (iii) The provisions by which patients, physicians, or hospitals may
21 seek reconsideration or appeal of adverse decisions by the private review agent;

22 (2) The type and qualifications of the personnel either employed or
23 under contract to perform the utilization review;

24 (3) The procedures and policies to ensure that a representative of the
25 private review agent is reasonably accessible to patients and providers 5 days a week
26 during normal business hours in this State;

27 (4) The policies and procedures to ensure that all applicable State and
28 federal laws to protect the confidentiality of individual medical records are followed;

29 (5) A copy of the materials designed to inform applicable patients and
30 providers of the requirements of the utilization review plan;

31 (6) A list of the third party payors for which the private review agent is
32 performing utilization review in this State;

1 (7) The policies and procedures to ensure that the private review agent
2 has a formal program for the orientation and training of the personnel either
3 employed or under contract to perform the utilization review;

4 (8) A list of the health care providers involved in establishing the specific
5 criteria and standards to be used in conducting utilization review; and

6 (9) Certification by the private review agent that the criteria and
7 standards to be used in conducting utilization review are:

8 (i) Objective;

9 (ii) Clinically valid;

10 (iii) Compatible with established principles of health care; and

11 (iv) Flexible enough to allow deviations from norms when justified
12 on a case by case basis.

13 (b) At least 10 days before a private review agent requires any revisions or
14 modifications to the specific criteria and standards to be used in conducting
15 utilization review of proposed or delivered services, the private review agent shall
16 submit those revisions or modifications to the [Secretary] COMMISSIONER.

17 15-9A-06.

18 (a) In this section, "utilization review" means a system for reviewing the
19 appropriate and efficient allocation of health care resources and services given or
20 proposed to be given to a patient or group of patients by a health care provider,
21 including a hospital or an intermediate care facility described under § 8-403(e) of
22 [this article] THE HEALTH - GENERAL ARTICLE.

23 (e) (1) In the event a patient or health care provider, including a physician,
24 intermediate care facility described under § 8-403(e) of [this article] THE HEALTH -
25 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
26 by a private review agent, the final determination of the appeal of the adverse
27 decision shall be made based on the professional judgment of a physician, or a panel
28 of other appropriate health care providers with at least 1 physician, selected by the
29 private review agent who is:

30 (i) 1. Board certified or eligible in the same specialty as the
31 treatment under review; or

32 2. Actively practicing or has demonstrated expertise in the
33 alcohol, drug abuse, or mental health service or treatment under review; and

34 (ii) Not compensated by the private review agent in a manner that
35 provides a financial incentive directly or indirectly to deny or reduce coverage.

1 (2) In the event a patient or health care provider, including a physician,
2 intermediate care facility described under § 8-403(e) of [this article] THE HEALTH -
3 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
4 by a private review agent, the final determination of the appeal of the adverse
5 decision shall be stated in writing and shall reference the specific criteria and
6 standards, including interpretive guidelines, upon which the denial or reduction in
7 coverage is based.

8 (g) (1) A private review agent that requires a health care provider to submit
9 a treatment plan in order for the private review agent to conduct utilization review of
10 proposed or delivered services for the treatment of a mental illness, emotional
11 disorder, or a drug abuse or alcohol abuse disorder:

12 (i) Shall accept the uniform treatment plan form adopted by the
13 [Secretary under § 19-1303(e)] COMMISSIONER UNDER § 15-9A-03(E) of this subtitle
14 as a properly submitted treatment plan form; and

15 (ii) May not impose any requirement to:

16 1. Modify the uniform treatment plan form or its content; or

17 2. Submit additional treatment plan forms.

18 (2) A uniform treatment plan form submitted under the provisions of
19 this subsection:

20 (i) Shall be properly completed by the health care provider; and

21 (ii) May be submitted by electronic transfer.

22 15-9A-07.

23 (a) Except as specifically provided in [§ 19-1305.1] § 15-9A-06 of this subtitle:

24 (1) All adverse decisions shall be made by a physician or a panel of other
25 appropriate health care providers with at least 1 physician on the panel.

26 (2) In the event a patient or health care provider, including a physician,
27 intermediate care facility described in § 8-403(e) of [this article] THE HEALTH -
28 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
29 by a private review agent, the final determination of the appeal of the adverse
30 decision shall be made based on the professional judgment of a physician or a panel of
31 other appropriate health care providers with at least 1 physician on the panel.

32 (3) In the event a patient or health care provider, including a physician,
33 intermediate care facility described in § 8-403(e) of [this article] THE HEALTH -
34 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
35 by a private review agent, the final determination of the appeal of the adverse
36 decision shall:

1 (i) Be stated in writing and provide an explanation of the reason
2 for the adverse decision; and

3 (ii) Reference the specific criteria and standards, including
4 interpretive guidelines, upon which the adverse decision is based.

5 15-9A-09.

6 (e) (1) The private review agent or health maintenance organization may
7 not require additional documentation from, require additional utilization review of, or
8 otherwise provide financial disincentives for an attending provider who orders care
9 for which coverage is required to be provided under this section, § 19-703 of [this
10 article] THE HEALTH - GENERAL ARTICLE, or § 15-811 of [the Insurance Article]
11 THIS ARTICLE.

12 15-9A-10.

13 (a) A certificate expires on the second anniversary of its effective date unless
14 the certificate is renewed for a 2-year term as provided in this section.

15 (b) Before the certificate expires, a certificate may be renewed for an
16 additional 2-year term if the applicant:

17 (1) Otherwise is entitled to the certificate;

18 (2) Pays to the [Secretary] COMMISSIONER the renewal fee set by the
19 [Secretary] COMMISSIONER through regulation; and

20 (3) Submits to the [Secretary] COMMISSIONER:

21 (i) A renewal application on the form that the [Secretary]
22 COMMISSIONER requires; and

23 (ii) Satisfactory evidence of compliance with any requirement
24 under this subtitle for certificate renewal.

25 (c) If the requirements of this section are met, the [Secretary]
26 COMMISSIONER shall renew a certificate.

27 [(d) The Secretary may delegate to the Commissioner the authority to renew a
28 certificate to any health insurer or nonprofit health service plan regulated under the
29 Insurance Article or health maintenance organization issued a certificate of authority
30 in accordance with Subtitle 7 of this title that meets the requirements of this subtitle
31 and all applicable regulations of the Secretary.]

32 15-9A-11.

33 (a) (1) The [Secretary] COMMISSIONER shall deny a certificate to any
34 applicant if, upon review of the application, the [Secretary] COMMISSIONER finds
35 that the applicant proposing to conduct utilization review does not:

1 (i) Have available the services of sufficient numbers of registered
2 nurses, medical records technicians or similarly qualified persons supported and
3 supervised by appropriate physicians to carry out its utilization review activities; and

4 (ii) Meet any applicable regulations the [Secretary]
5 COMMISSIONER adopts under this subtitle relating to the qualifications of private
6 review agents or the performance of utilization review.

7 (2) The [Secretary] COMMISSIONER shall deny a certificate to any
8 applicant that does not provide assurances satisfactory to the [Secretary]
9 COMMISSIONER that:

10 (i) The procedures and policies of the private review agent will
11 protect the confidentiality of medical records in accordance with applicable State and
12 federal laws; and

13 (ii) The private review agent will be accessible to patients and
14 providers 5 working days a week during normal business hours in this State.

15 (b) The [Secretary] COMMISSIONER may revoke a certificate if the holder
16 does not comply with performance assurances under this section, violates any
17 provision of this subtitle, or violates any regulation adopted under any provision of
18 this subtitle.

19 (c) (1) Before denying or revoking a certificate under this section, the
20 [Secretary] COMMISSIONER shall provide the applicant or certificate holder with
21 reasonable time to supply additional information demonstrating compliance with the
22 requirements of this subtitle and the opportunity to request a hearing.

23 (2) If an applicant or certificate holder requests a hearing, the
24 [Secretary] COMMISSIONER shall send a hearing notice by certified mail, return
25 receipt requested, at least 30 days before the hearing.

26 (3) The [Secretary] COMMISSIONER shall hold the hearing in
27 accordance with Title 10, Subtitle 2 of the State Government Article.

28 15-9A-12.

29 The [Secretary] COMMISSIONER may waive the requirements of this subtitle
30 for a private review agent that operates solely under contract with the federal
31 government for utilization review of patients eligible for hospital services under Title
32 XVIII of the Social Security Act.

33 15-9A-13.

34 The [Secretary] COMMISSIONER shall periodically provide a list of private
35 review agents issued certificates and the renewal date for those certificates to:

36 (1) The Maryland Chamber of Commerce;

1 (2) The Medical and Chirurgical Faculty of Maryland;

2 (3) The Maryland Hospital Association;

3 (4) All hospital utilization review programs; and

4 (5) Any other business or labor organization requesting the list.

5 15-9A-14.

6 The [Secretary] COMMISSIONER may establish reporting requirements to:

7 (1) Evaluate the effectiveness of private review agents; and

8 (2) Determine if the utilization review programs are in compliance with
9 the provisions of this section and applicable regulations.

10 15-9A-17.

11 (b) (1) In addition to the provisions of subsection (a) of this section, the
12 [Secretary] COMMISSIONER may impose an administrative penalty of up to $1,000
13 for a violation of any provision of this subtitle.

14 (2) The [Secretary] COMMISSIONER shall adopt regulations to provide
15 standards for the imposition of an administrative penalty under paragraph (1) of this
16 subsection.

17 15-9A-18.

18 (a) Any person aggrieved by a final decision of the [Secretary]
19 COMMISSIONER in a contested case under this subtitle may take a direct judicial
20 appeal.

21 Subtitle 10. Claims and Utilization Review.

22 15-1001.

23 (a) This section applies to insurers and nonprofit health service plans that
24 propose to issue or deliver individual, group, or blanket health insurance policies or
25 contracts in the State or to administer health benefit programs that provide for the
26 coverage of hospital benefits and the utilization review of those benefits.

27 (b) Each entity subject to this section shall:

28 (1) have a certificate issued under [Title 19, Subtitle 13 of the Health -
29 General Article] SUBTITLE 9A OF THIS TITLE;

30 (2) contract with a private review agent that has a certificate issued
31 under [Title 19, Subtitle 13 of the Health - General Article] SUBTITLE 9A OF THIS
32 TITLE; or

1 (3) contract with or delegate utilization review to a hospital utilization
2 review program approved under § 19-319(d) of the Health - General Article.

3 (c) Notwithstanding any other provision of this article, if the medical
4 necessity of providing a covered benefit is disputed, an entity subject to this section
5 that does not meet the requirements of subsection (b) of this section shall pay any
6 person entitled to reimbursement under the policy, contract, or certificate in
7 accordance with the determination of medical necessity by the hospital utilization
8 review program approved under § 19-319(d) of the Health - General Article.

9 Subtitle 12. Maryland Health Insurance Reform Act.

10 15-1201.

11 [(d) "Commission" means the Maryland Health Care Access and Cost
12 Commission established under Title 19, Subtitle 15 of the Health - General Article.]

13 (n) "Standard Plan" means the Comprehensive Standard Health Benefit Plan
14 adopted by the [Commission] COMMISSIONER in accordance with § 15-1207 of this
15 subtitle [and Title 19, Subtitle 15 of the Health - General Article].

16 15-1205.

17 (c) (1) Based on the adjustments allowed under subsection (a)(2) of this
18 section, a carrier may charge a rate that is 33% above or below the community rate.

19 (2) On or before October 1, 1998, the Commissioner, in conjunction with
20 the [Health Care Access and Cost Commission] HEALTH CARE ACCESS AND SYSTEMS
21 PERFORMANCE COMMISSION, shall submit a report to the Governor and, in
22 accordance with § 2-1246 of the State Government Article, the General Assembly on
23 the feasibility and desirability of requiring carriers to charge rates that are less than
24 33% above or below the community rate for health benefit plans.

25 15-1207.

26 (a) [In accordance with Title 19, Subtitle 15 of the Health - General Article,
27 the Commission] THE COMMISSIONER, IN CONSULTATION WITH THE HEALTH CARE
28 ACCESS AND SYSTEMS PERFORMANCE COMMISSION, shall adopt regulations that
29 specify:

30 (1) the [Comprehensive Standard Health Benefit Plan] STANDARD
31 PLAN to apply under this subtitle; and

32 (2) a modified health benefit plan for medical savings accounts that
33 qualify under the federal Health Insurance Portability and Accountability Act of 1996,
34 including:

35 (i) a waiver of deductibles as permitted under federal law;

36 (ii) minimum funding standards for medical savings accounts; and

1 (iii) authorization for offering the modified plan only by those
2 persons who offer the [Comprehensive Standard Health Benefit Plan] STANDARD
3 PLAN adopted in accordance with item (1) of this subsection.

4 (b) The [Commission] COMMISSIONER shall require that the minimum
5 benefits allowed to be offered in the Standard Plan:

6 (1) by a health maintenance organization, shall include at least the
7 actuarial equivalent of the minimum benefits required to be offered by a federally
8 qualified health maintenance organization; and

9 (2) by an insurer or nonprofit health service plan on an
10 expense-incurred basis, shall be actuarially equivalent to at least the minimum
11 benefits required to be offered under item (1) of this subsection.

12 (c) (1) Subject to paragraph (2) of this subsection, the [Commission]
13 COMMISSIONER shall exclude or limit benefits or adjust cost-sharing arrangements
14 in the Standard Plan if the average rate for the Standard Plan exceeds 12% of the
15 average annual wage in the State.

16 (2) The [Commission] COMMISSIONER annually shall determine the
17 average rate for the Standard Plan by using the average rate submitted by each
18 carrier that offers the Standard Plan.

19 (d) In establishing benefits, the [Commission] COMMISSIONER shall judge
20 preventive services, medical treatments, procedures, and related health services
21 based on:

22 (1) their effectiveness in improving the health status of individuals;

23 (2) their impact on maintaining and improving health and on reducing
24 the unnecessary consumption of health care services; and

25 (3) their impact on the affordability of health care coverage.

26 (e) The [Commission] COMMISSIONER may exclude:

27 (1) a health care service, benefit, coverage, or reimbursement for covered
28 health care services that is required under this article or the Health - General Article
29 to be provided or offered in a health benefit plan that is issued or delivered in the
30 State by a carrier; or

31 (2) reimbursement required by statute, by a health benefit plan for a
32 service when that service is performed by a health care provider who is licensed under
33 the Health Occupations Article and whose scope of practice includes that service.

34 (f) The Standard Plan shall include uniform deductibles and cost-sharing
35 associated with its benefits, as determined by the [Commission] COMMISSIONER.

1 (g) In establishing cost-sharing as part of the Standard Plan, the
2 [Commission] COMMISSIONER shall:

3 (1) include cost-sharing and other incentives to help prevent consumers
4 from seeking unnecessary services;

5 (2) balance the effect of cost-sharing in reducing premiums and in
6 affecting utilization of appropriate services; and

7 (3) limit the total cost-sharing that may be incurred by an individual in
8 a year.

9 15-1214.

10 Notwithstanding any other provision of this subtitle, health benefit plans shall
11 reimburse hospitals in accordance with rates approved by the [State Health Services
12 Cost Review Commission] MARYLAND HEALTH CARE ACCESS AND SYSTEMS
13 PERFORMANCE COMMISSION.

14 **Article - State Government**

15 8-403.

16 (I) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (E) OF THIS SECTION,
17 ON OR BEFORE JULY 1, 2007, AN EVALUATION SHALL BE MADE OF THE STATE
18 HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION ESTABLISHED
19 UNDER TITLE 19, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE AND THE
20 REGULATIONS THAT RELATE TO THE STATE HEALTH CARE ACCESS AND SYSTEMS
21 PERFORMANCE COMMISSION.

22 **Article 43C - Maryland Health and Higher Educational Facilities Authority**

23 16A.

24 (a) In this section, the following terms have the meanings indicated.

25 (1) "Closure costs" means the reasonable costs determined by the
26 [Health Services Cost Review Commission] HEALTH CARE ACCESS AND SYSTEMS
27 PERFORMANCE COMMISSION to be incurred in connection with the closure or
28 delicensure of a hospital, including expenses of operating the hospital, payments to
29 employees, employee benefits, fees of consultants, insurance, security services,
30 utilities, legal fees, capital costs, costs of terminating contracts with vendors,
31 suppliers of goods and services and others, debt service, contingencies and other
32 necessary or appropriate costs and expenses.

33 (2) (i) "Public body obligation" means any bond, note, evidence of
34 indebtedness or other obligation for the payment of borrowed money issued by the
35 Authority, any public body as defined in Article 31, § 9 of the Code, the Mayor and
36 City Council of Baltimore, or any municipal corporation subject to the provisions of
37 Article XI-E of the Maryland Constitution.

1 (ii) "Public body obligation" does not include any obligation, or
2 portion of any such obligation, if:

3 1. The principal of and interest on the obligation or such
4 portion thereof is:

5 A. Insured by an effective municipal bond insurance policy;
6 and

7 B. Issued on behalf of a hospital that voluntarily closed in
8 accordance with [§ 19-115(l)] § 19-120(L) of the Health - General Article;

9 2. The proceeds of the obligation or such portion thereof were
10 used for the purpose of financing or refinancing a facility or part thereof which is used
11 primarily to provide outpatient services at a location other than the hospital; or

12 3. The proceeds of the obligation or such portion thereof were
13 used to finance or refinance a facility or part thereof which is primarily used by
14 physicians who are not employees of the hospital for the purpose of providing services
15 to nonhospital patients.

16 (b) (1) The General Assembly finds that the failure to provide for the
17 payment of public body obligations of a closed or delicensed hospital could have a
18 serious adverse effect on the ability of Maryland health care facilities, and potentially
19 the ability of the State and local governments, to secure subsequent financing
20 through the issuance of tax-exempt bonds.

21 (2) The purpose of this section is to preserve the access of Maryland's
22 health care facilities to adequate financing by establishing a program to facilitate the
23 refinancing and payment of public body obligations of a closed or delicensed hospital.

24 (c) The Maryland Hospital Bond Program is hereby created within the
25 Maryland Health and Higher Educational Facilities Authority. The Program shall
26 provide for the payment and refinancing of public body obligations of a hospital, as
27 defined in § 19-301 of the Health - General Article, if:

28 (1) The closure of a hospital is in accordance with [§ 19-115(l)] §
29 19-120(L) of the Health - General Article or the delicensure of a hospital is in
30 accordance with § 19-325 of the Health - General Article;

31 (2) There are public body obligations issued on behalf of the hospital
32 outstanding;

33 (3) The closure of the hospital is not the result of a merger or
34 consolidation with 1 or more other hospitals; and

35 (4) The hospital plan for closure or delicensure and the related financing
36 or refinancing plan is acceptable to the Secretary of Health and Mental Hygiene and
37 the Authority.

1 (d) (1) The [Health Resources Planning Commission] HEALTH CARE
2 ACCESS AND SYSTEMS PERFORMANCE COMMISSION shall give:

3 (i) The Authority [and the Health Services Cost Review
4 Commission] written notification of the filing by a hospital with the [Health
5 Resources Planning Commission] HEALTH CARE ACCESS AND SYSTEMS
6 PERFORMANCE COMMISSION of any written notice of intent to close under [§
7 19-115(l)] § 19-120(L) of the Health - General Article; or

8 (ii) The Authority written notification of the filing with the
9 Secretary of Health and Mental Hygiene of a petition for the delicensure of a hospital
10 under § 19-325 of the Health - General Article.

11 (2) The notice required by this subsection shall be given within 10 days
12 after the filing of the notice or petition.

13 (e) (1) The [Health Resources Planning Commission] HEALTH CARE
14 ACCESS AND SYSTEMS PERFORMANCE COMMISSION and the Secretary of Health and
15 Mental Hygiene shall give the Authority [and the Health Services Cost Review
16 Commission] written notification of[:

17 (i) A determination by the Health Resources Planning Commission
18 to exempt a hospital closure from the certificate of need requirement pursuant to §
19 19-115(l) of the Health - General Article; or

20 (ii) A] A determination by the Secretary of Health and Mental
21 Hygiene to delicense a hospital pursuant to § 19-325 of the Health - General Article.

22 (2) The [Health Resources Planning Commission] HEALTH CARE
23 ACCESS AND SYSTEMS PERFORMANCE COMMISSION and the Secretary of Health and
24 Mental Hygiene shall submit the written notification required in paragraph (1) of this
25 subsection no later than 150 days prior to the scheduled date of the hospital [closure
26 or] delicensure and shall include the name and location of the hospital, and the
27 scheduled date of hospital [closure or] delicensure.

28 (f) (1) A hospital that intends to close or is scheduled to be delicensed shall
29 provide the Authority and the [Health Services Cost Review Commission] HEALTH
30 CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION with a written statement
31 of any outstanding public body obligations issued on behalf of the hospital, which
32 shall include:

33 (i) The name of each issuer of a public body obligation on behalf of
34 the hospital;

35 (ii) The outstanding principal amount of each public body
36 obligation and the due dates for payment or any mandatory redemption or purchase
37 thereof;

38 (iii) The due dates for the payment of interest on each public body
39 obligation and the interest rates; and

1 (iv) Any documents and information pertaining to the public body
2 obligations as the Authority or the [Health Services Cost Review Commission]
3 HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION may request.

4 (2) The statement required in paragraph (1) of this subsection shall be
5 filed by the hospital:

6 (i) In the case of closure pursuant to [§ 19-115(l)] § 19-120(L) of the
7 Health - General Article, within 10 days after the date of filing with the [Health
8 Resources Planning Commission] HEALTH CARE ACCESS AND SYSTEMS
9 PERFORMANCE COMMISSION of written notice of intent to close; or

10 (ii) In the case of delicensure pursuant to § 19-325 of the Health -
11 General Article, at least 150 days prior to the scheduled date of delicensure.

12 (g) (1) The [Health Services Cost Review Commission] HEALTH CARE
13 ACCESS AND SYSTEMS PERFORMANCE COMMISSION may determine to provide for the
14 payment of all or any portion of the closure costs of a hospital having outstanding
15 public body obligations if the [Health Services Cost Review Commission] HEALTH
16 CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION determines that payment
17 of the closing costs is necessary or appropriate to:

18 (i) Encourage and assist the hospital to close; or

19 (ii) Implement the program created by this section.

20 (2) In making the determinations under this subsection, the [Health
21 Services Cost Review Commission] HEALTH CARE ACCESS AND SYSTEMS
22 PERFORMANCE COMMISSION shall consider:

23 (i) The amount of the system-wide savings to the State health care
24 system expected to result from the closure or delicensure of the hospital over:

25 1. The period during which the fee to provide for the
26 payment of the closure costs or any bonds or notes issued to finance the closure costs
27 will be assessed; or

28 2. A period ending 5 years after the date of closure or
29 delicensure, whichever is the longer; and

30 (ii) The recommendations of [the Health Resources Planning
31 Commission and] the Authority.

32 (3) Within 60 days after receiving the notice of closure or delicensure
33 required by subsection (e), the [Health Services Cost Review Commission] HEALTH
34 CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION shall:

35 (i) Determine whether to provide for the payment of all or any
36 portion of the closure costs of the hospital in accordance with this subsection; and

1 (ii) Give written notification of such determination to [the Health
2 Resources Planning Commission and] the Authority.

3 (4) The provisions of this subsection may not be construed to require the
4 [Health Services Cost Review Commission] HEALTH CARE ACCESS AND SYSTEMS
5 PERFORMANCE COMMISSION to make provision for the payment of any closure costs
6 of a closed or delicensed hospital.

7 (5) In any suit, action or proceeding involving the validity or
8 enforceability of any bond or note issued to finance any closure costs or any security
9 for a bond or note, the determinations of the [Health Services Cost Review
10 Commission] HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION
11 under this subsection shall be conclusive and binding.

12 (h) (1) Within 60 days after receiving the written statement required by
13 subsection (f) of this section, the Authority shall prepare a schedule of payments
14 necessary to meet the public body obligations of the hospital.

15 (2) As soon as practicable after receipt of the notice of closure or
16 delicensure required by subsection (e) and after consultation with the issuer of each
17 public body obligation and the [Health Services Cost Review Commission] HEALTH
18 CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION, the Authority shall
19 prepare a proposed plan to finance, refinance or otherwise provide for the payment of
20 public body obligations. The proposed plan may include any tender, redemption,
21 advance refunding or other technique deemed appropriate by the Authority.

22 (3) As soon as practicable after receipt of written notification that the
23 [Health Services Cost Review Commission] HEALTH CARE ACCESS AND SYSTEMS
24 PERFORMANCE COMMISSION has determined to provide for the payment of any
25 closure costs of a hospital pursuant to subsection (g) of this section, the Authority
26 shall prepare a proposed plan to finance, refinance or otherwise provide for the
27 payment of the closure costs set forth in the notice.

28 (4) Upon the request of the [Health Services Cost Review Commission]
29 HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION, the Authority
30 may begin preparing the plan or plans required by this subsection before:

31 (i) [The final determination by the Health Resources Planning
32 Commission to exempt a hospital closure from the certificate of need requirement
33 pursuant to § 19-115(l) of the Health - General Article;

34 (ii)] Any final determination of delicensure by the Secretary of
35 Health and Mental Hygiene pursuant to § 19-325 of the Health - General Article; or

36 [(iii)] (II) Any final determination by the [Health Services Cost
37 Review Commission] HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE
38 COMMISSION to provide for the payment of any closure costs of the hospital.

39 (5) The Authority shall promptly submit the schedule of payments and
40 the proposed plan or plans required by this subsection to the [Health Services Cost

1 Review Commission] HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE
2 COMMISSION.

3 (i) (1) The Authority may issue negotiable bonds or notes for the purpose of
4 financing, refinancing or otherwise providing for the payment of public body
5 obligations or any closure costs of a hospital in accordance with any plan developed
6 pursuant to subsection (h) of this section.

7 (2) The bonds or notes shall be payable from the fees provided pursuant
8 to subsection (j) of this section or from other sources as may be provided in the plan.

9 (3) The bonds or notes shall be authorized, sold, executed and delivered
10 as provided for in this article and shall have terms consistent with all existing
11 constitutional and legal requirements.

12 (4) In connection with the issuance of any bond or note, the Authority
13 may assign its rights under any loan, lease or other financing agreement between the
14 Authority or any other issuer of a public body obligation and the closed or delicensed
15 hospital to the State or appropriate agency in consideration for the payment of any
16 public body obligation as provided in this section.

17 (j) (1) On the date of closure or delicensure of any hospital for which a
18 financing or refinancing plan has been developed in accordance with subsection (h) of
19 this section, the [Health Services Cost Review Commission] HEALTH CARE ACCESS
20 AND SYSTEMS PERFORMANCE COMMISSION shall assess a fee on all hospitals as
21 provided in [§ 19-207.2] § 19-142 of the Health - General Article in an amount
22 sufficient to:

23 (i) Pay the principal and interest on any public body obligations, or
24 any bonds or notes issued by the Authority pursuant to subsection (i) of this section to
25 finance or refinance public body obligations;

26 (ii) Pay any closure costs or the principal and interest on any bonds
27 or notes issued by the Authority pursuant to subsection (i) of this section to finance or
28 refinance any closure costs;

29 (iii) Maintain any reserve required in the resolution, trust
30 agreement or other financing agreement securing public body obligations, bonds, or
31 notes;

32 (iv) Pay any required financing fees or other similar charges; and

33 (v) Maintain reserves deemed appropriate by the Authority to
34 ensure that the amounts provided in this subsection are satisfied in the event any
35 hospital defaults in paying the fees.

36 (2) The fee assessed each hospital shall be equal to that portion of the
37 total fees required to be assessed that is equal to the ratio of the actual gross patient
38 revenues of the hospital to the total gross patient revenues of all hospitals,
39 determined as of the date or dates deemed appropriate by the Authority after

1 consultation with the [Health Services Cost Review Commission] HEALTH CARE
2 ACCESS AND SYSTEMS PERFORMANCE COMMISSION.

3 (3) Each hospital shall pay the fee directly to the Authority, any trustee
4 for the holders of any bonds or notes issued by the Authority pursuant to subsection
5 (i) of this section, or as otherwise directed by the Authority. The fee may be assessed
6 at any time necessary to meet the payment requirements of this subsection.

7 (4) The fees assessed may not be subject to supervision or regulation by
8 any department, commission, board, body or agency of this State. Any pledge of these
9 fees to any bonds or notes issued pursuant to this section or to any other public body
10 obligations, shall immediately subject such fees to the lien of the pledge without any
11 physical delivery or further act. The lien of the pledge shall be valid and binding
12 against all parties having claims of any kind in tort, contract or otherwise against the
13 Authority or any closed or delicensed hospital, irrespective of whether the parties
14 have notice.

15 (5) In the event the [Health Services Cost Review Commission] HEALTH
16 CARE ACCESS AND SYSTEMS PERFORMANCE COMMISSION shall terminate by Law,
17 the Secretary of Health and Mental Hygiene, in accordance with the provisions of this
18 subsection, shall impose a fee on all hospitals licensed pursuant to § 19-318 of the
19 Health - General Article.

20 (k) (1) Notwithstanding any other provision of this article, any action taken
21 by the Authority to provide for the payment of public body obligations shall be for the
22 purpose of maintaining the credit rating of this State, its agencies, instrumentalities,
23 and political subdivisions, ensuring their access to the credit markets, and may not
24 constitute any payment by or on behalf of a closed or delicensed hospital. A hospital is
25 not relieved of its obligations with respect to the payment of public body obligations.
26 The Authority shall be subrogated to the rights of any holders or issuers of public
27 body obligations, as if the payment or provision for payment had not been made.

28 (2) The Authority may proceed against any guaranty or other collateral
29 securing the payment of public body obligations of a closed or delicensed hospital
30 which was provided by any entity associated with the hospital if such action is
31 determined by the Authority to be:

32 (i) Necessary to protect the interests of the holders of the public
33 body obligations; or

34 (ii) Consistent with the public purpose of encouraging and assisting
35 the hospital to close.

36 (3) In making the determination required under paragraph (2) of this
37 subsection, the Authority shall consider:

38 (i) The circumstances under which the guaranty or other collateral
39 was provided; and

1 (ii) The recommendations of the [Health Services Cost Review
2 Commission and the Health Resources Planning Commission] HEALTH CARE ACCESS
3 AND SYSTEMS PERFORMANCE COMMISSION.

4 (4) Any amount realized by the Authority or any assignee of the
5 Authority in the enforcement of any claim against a hospital for which a plan has
6 been developed in accordance with subsection (h) of this section shall be applied to
7 offset the amount of the fee required to be assessed by the [Health Services Cost
8 Review Commission] HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE
9 COMMISSION pursuant to subsection (j) of this section. The costs and expenses of
10 enforcing the claim, including any costs for maintaining the property prior to its
11 disposition, shall be deducted from this amount.

12 (l) It is the purpose and intent of this section that the [Health Services Cost
13 Review Commission, the Health Resources Planning Commission,] HEALTH CARE
14 ACCESS AND SYSTEMS PERFORMANCE COMMISSION and the Authority consult with
15 each other and take into account each others' recommendations in making the
16 determinations required to be made under this section.

17 (m) Notwithstanding any other provision of this section, in any suit, action or
18 proceeding involving the validity or enforceability of any bond or note or any security
19 for a bond or note, the determinations of the Authority under this section shall be
20 conclusive and binding.

21 (n) The [Health Services Cost Review Commission, the Health Resources
22 Planning Commission,] HEALTH CARE ACCESS AND SYSTEMS PERFORMANCE
23 COMMISSION or the Authority may waive any notice required to be given to it under
24 this section.

25 SECTION 7. AND BE IT FURTHER ENACTED, That the terms of the initial
26 members of the Health Care Access and Systems Performance Commission shall
27 expire as follows:

28 (a) 3 members in 2002;

29 (b) 3 members in 2003;

30 (c) 3 members in 2004; and

31 (d) 2 members in 2005.

32 SECTION 8. AND BE IT FURTHER ENACTED, That:

33 (a) all property of any kind, including personal property, records,
34 fixtures, appropriations, credits, assets, liabilities, obligations, rights, and privileges,
35 held by the State Health Resources Planning Commission, the State Health Services
36 Cost Review Commission, and the Maryland Health Care Access and Cost
37 Commission shall be and hereby are transferred to the State Health Care Access and
38 Systems Performance Commission;

1 (b) except as otherwise provided by law, all contracts, agreements,
2 grants, or other obligations entered into prior to July 1, 1998 by the State Health
3 Resources Planning Commission, the State Health Services Cost Review Commission,
4 or the Maryland Health Care Access and Cost Commission, and which by their terms
5 are to continue in effect on or after July 1, 1998, shall be valid, legal, and binding
6 obligations of the State Health Care Access and Systems Performance Commission,
7 under the terms of the obligations; and

8 (c) any transaction affected by any change of nomenclature under this
9 Act, and validly entered into before July 1, 1998, and every right, duty, or interest
10 flowing from the transaction, remains valid on and after July 1, 1998 as if the change
11 of nomenclature had not occurred.

12 SECTION 9. AND BE IT FURTHER ENACTED, That all employees who are
13 transferred to the State Health Care Access and Systems Performance Commission
14 from the State Health Resources Planning Commission, the State Health Services
15 Cost Review Commission, and the Maryland Health Care Access and Cost
16 Commission upon the implementation of this Act shall be so transferred without
17 diminution of their rights, benefits, or employment or retirement status.

18 SECTION 10. AND BE IT FURTHER ENACTED, That:

19 (a) the publishers of the Annotated Code of Maryland, subject to the
20 approval of the Department of Legislative Services, shall propose the correction of any
21 agency names and titles throughout the Code that are rendered incorrect by this Act;
22 and

23 (b) subject to the approval of the Executive Director of the Department of
24 Legislative Services, the publishers of the Annotated Code of Maryland shall correct
25 any cross-references that are rendered incorrect by this Act.

26 SECTION 11. AND BE IT FURTHER ENACTED, That, the State Health Care
27 Access and Systems Performance Commission, the Department of Health and Mental
28 Hygiene, and the Maryland Insurance Administration shall until July 1, 2000 report
29 quarterly to the Senate Finance Committee, the House Economic Matters Committee,
30 and the House Environmental Matters Committee on the implementation of this Act.
31 Beginning January 1, 2001, the Health Care Access and Systems Performance
32 Commission shall annually offer to brief the appropriate committees of the General
33 Assembly on the work of the Commission.

34 SECTION 12. AND BE IT FURTHER ENACTED, That the State Health Care
35 Access and Systems Performance Commission shall become operationalized on
36 January 1, 1999.

37 SECTION 13. AND BE IT FURTHER ENACTED, That the changes made to §
38 19-139 of the Health - General Article shall take effect January 1, 1999.

39 SECTION 14. AND BE IT FURTHER ENACTED, That this Act shall take effect
40 July 1, 1998.