

Chapter 523

(Senate Bill 485)

AN ACT concerning

Continuing Care Retirement Communities – Regulation

FOR the purpose of requiring certain providers to set aside operating reserves that, before a certain date, equal a certain percentage of certain expenses of a facility; requiring certain providers to set aside operating reserves that, ~~on or after~~ beginning on a certain date, equal a certain percentage of certain expenses of a facility; beginning on a certain date, providing for the manner in which certain requirements under this Act relating to assets held by providers as operating reserves shall be met; beginning on a certain date, providing that certain assets held by providers may be encumbered under certain circumstances; requiring providers of certain facilities, for purposes of a certain operating reserve requirement, to make a certain calculation based on certain operating expenses; adding to the information to be included in a disclosure statement; requiring certain providers to make certain information related to meetings of a governing body available to subscribers within a certain time period; requiring providers to make a certain response to a grievance in writing; requiring providers to make available a copy of a certain budget; requiring certain marketing materials to include a certain disclaimer; providing that certain providers may not sell or make certain transfers of ownership of a facility unless the Department of Aging approves the sale or transfer; providing for the application of certain provisions of this Act; adding to the information to be included in a continuing care agreement; authorizing the Department of Aging to consider whether a continuing care agreement complies with certain laws; providing for the circumstances under which a provider is not required to submit certain agreements to the Department of Aging for approval; requiring a provider to make certain statements in its continuing care agreement under certain circumstances; authorizing a provider to include certain provisions in its continuing care agreement; ~~requiring the Secretary of Aging and the Insurance Commissioner to conduct certain studies and make certain reports on or before certain dates;~~ making the provisions of this Act severable; making certain stylistic and conforming changes; and generally relating to the regulation of continuing care retirement communities.

BY repealing and reenacting, with amendments,

Article – Human Services

Section 10–420(b), 10–423(a), 10–425(a), 10–427, 10–428, 10–429, 10–432, 10–444(a) and (b), and 10–445

Annotated Code of Maryland

(2007 Volume and 2011 Supplement)

BY adding to

Article – Human Services

Section 10–430 and 10–443

Annotated Code of Maryland

(2007 Volume and 2011 Supplement)

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

Article – Human Services

10–420.

(b) (1) Except as otherwise provided in this part, a provider shall set aside for each facility subject to this subtitle operating reserves **THAT:**

(I) **BEFORE JANUARY 1, 2023**, equal [to] 15% of the facility's net operating expenses for the most recent fiscal year for which a certified financial statement is available; **AND**

(II) ~~ON OR AFTER~~ **BEGINNING JANUARY 1, 2023, EQUAL 25% OF THE FACILITY'S NET OPERATING EXPENSES FOR THE MOST RECENT FISCAL YEAR FOR WHICH A CERTIFIED FINANCIAL STATEMENT IS AVAILABLE.**

(2) The provider shall keep the operating reserves in a reasonably liquid form in the judgment of the provider.

(3) **BEGINNING JANUARY 1, 2014, THE ASSETS HELD BY THE PROVIDER AS THE OPERATING RESERVES REQUIRED UNDER THIS SUBSECTION:**

(I) **EXCEPT AS PROVIDED IN PARAGRAPH (4) OF THIS SUBSECTION, SHALL BE UNRESTRICTED CASH AND INVESTMENTS; AND**

(II) **MAY NOT:**

1. ~~INCLUDE~~ **BE MET WITH A LINE OF CREDIT; OR**

2. **EXCEPT AS PROVIDED IN PARAGRAPH (4) OF THIS SUBSECTION, BE HYPOTHECATED, PLEDGED AS COLLATERAL, OR OTHERWISE ENCUMBERED BY THE PROVIDER IN ANY MANNER.**

(4) **BEGINNING JANUARY 1, 2014, THE ASSETS HELD BY THE PROVIDER AS THE OPERATING RESERVES MAY BE ENCUMBERED IF:**

(I) THE ASSETS ARE ENCUMBERED BY CONTRACTUAL OBLIGATIONS UNDERTAKEN BEFORE JANUARY 1, 2014, THAT HAVE NOT MATERIALLY CHANGED SINCE JANUARY 1, 2014; OR

(II) THE ASSETS ARE ENCUMBERED AS PART OF A GENERAL SECURITY PLEDGE OF ASSETS OR SIMILAR COLLATERALIZATION THAT IS PART OF THE PROVIDER'S LONG-TERM CAPITAL DEBT COVENANTS INCLUDED IN THE PROVIDER'S LONG-TERM DEBT INDENTURE OR SIMILAR FINANCIAL INSTRUMENT BUT WHICH REMAIN AVAILABLE TO THE PROVIDER TO PAY OPERATING EXPENSES WITHOUT SUBSTANTIAL RESTRICTIONS OR LIMITATIONS.

10-423.

(a) For a facility that has not been the subject of a conversion and that has residents who are not parties to continuing care agreements, the provider shall [set aside] **CALCULATE THE AMOUNT OF** operating reserves [equal to at least 15% of] **REQUIRED UNDER § 10-420 OF THIS SUBTITLE BASED ON** the pro rata proportion of the net operating expenses [calculated] **AS SPECIFIED** under subsection (b) of this section.

10-425.

(a) A disclosure statement shall include:

(1) A TABLE OF CONTENTS;

[(1)] (2) the name, address, and description of the facility and the identity of the owner or owners of the facility and the land on which it is located;

[(2)] (3) the name and address of the provider and of any parent or subsidiary;

[(3)] (4) the organizational structure and management of the provider, including:

(i) for a corporation or limited liability company, its name, the state in which it is incorporated or formed, and the name of the chief executive officer;

(ii) for a partnership, the names of the general partners, the state governing its formation, and the name of the primary individual responsible for managing it;

(iii) for an unincorporated association, the names of the members, the state governing its activities, and the name of the primary individual responsible for managing it;

(iv) for a partnership that has a corporation or limited liability company as one or more of its general partners, the name of each corporation or limited liability company, the state in which it is incorporated or formed, and the name of the chief executive officer;

(v) for a trust, the name of the trustee, the names of the owners of beneficial interests in the trust, the state governing it, and the name of the primary individual responsible for overseeing its activities; and

(vi) a statement whether the provider is qualified, or intends to qualify, as a tax-exempt organization under the Internal Revenue Code;

[(4)] (5) the name and occupation of each officer, director, trustee, managing or general partner, and each person with a 10% or greater equity or beneficial interest in the provider, and a description of the person's financial interest in or occupation with the provider;

[(5)] (6) the name and address of any entity in which a person identified in item **[(4)] (5)** of this subsection has a 10% or greater financial interest and that is anticipated to provide goods, premises, or services with a value of \$10,000 or more to the facility or provider in a fiscal year and a description of the goods, premises, or services and their anticipated cost to the facility or provider, which need not include salary, wage, or benefit information of employees of the provider;

[(6)] (7) a description of any matter in which an individual identified in item **[(4)] (5)** of this subsection:

(i) has been convicted of a felony or pleaded nolo contendere to a felony charge, if the felony involved fraud, embezzlement, fraudulent conversion, or misappropriation of property;

(ii) has been held liable or enjoined in a civil action by final judgment, if the civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation as a fiduciary;

(iii) has been subject to an effective injunctive or restrictive order of a court of record in an action that arose out of or related to business activity or health care, including an action that affected a license to operate a facility or service for senior, impaired, or dependent persons; or

(iv) in the past 10 years, had a state or federal license or permit suspended or revoked because a governmental unit brought an action that arose out of or related to business activity or health care, including an action that affected a license to operate a facility or service for senior, impaired, or dependent persons;

~~[(7)]~~ **(8)** a description of the provider's form of governance and the composition of its governing body, and a statement that the provider will satisfy the requirements of §§ 10–426 and 10–427 of this subtitle;

(9) IF THE PROVIDER HAS A GOVERNING BODY, A DESCRIPTION OF THE PROCESS USED BY THE PROVIDER TO:

(I) SELECT A SUBSCRIBER MEMBER OF ITS GOVERNING BODY; AND

(II) SATISFY THE REQUIREMENTS OF § 10–427(A) OF THIS SUBTITLE.

~~[(8)]~~ **(10)** a statement of any affiliation of the provider with a religious, charitable, or other nonprofit organization, and the extent of the organization's responsibility for the financial and contractual obligations of the provider;

~~[(9)]~~ **(11)** if the facility will be managed on a day-to-day basis by a person other than an individual who is directly employed by the provider, the name of the proposed manager or management company and a description of the business experience of the manager or company in operating or managing similar facilities;

~~[(10)]~~ **(12)** a copy of the most recent certified financial statement obtainable under generally accepted accounting principles;

~~[(11)]~~ **(13)** a description of the long-term financing for the facility;

~~[(12)]~~ **(14)** a cash flow forecast for the current and the next two fiscal years;

~~[(13)]~~ **(15)** a description of any activity related to a renovation, expansion, or new development during the preceding fiscal year or proposed for the current fiscal year;

~~[(14)]~~ **(16)** a description of:

(i) the steps that have been or will be taken to comply with the operating reserve requirements under § 10–420(b) of this subtitle; and

(ii) the provider's investment policy related to the required reserves, including how often and by whom the reserve fund investment is reviewed;

~~[(15)]~~ **(17)** a description of the financial arrangements that the provider has made, if any, to address the renewal and replacement of the buildings and

improvements at the facility, such as the establishment of a renewal and replacement fund;

[(16)] **(18)** if the facility has not reached 85% occupancy of its independent living units, a summary of the feasibility study;

[(17)] **(19)** if applicable, a description of the conditions under which the provider may be issued an initial certificate of registration and may use escrowed deposits;

[(18)] **(20)** a description of all basic fees, including entrance fees, fees for health related services, and periodic fees that the provider collects from subscribers, and the amount and frequency of any fee changes during the previous 5 years or, if the facility has been in operation less than 5 years, for each year of operation;

[(19)] **(21)** a summary of the basic services provided or proposed to be provided at the facility under the continuing care agreement, including the extent to which health related services are provided, that clearly states which services are indicated in the agreement as included in the basic fee and which services are or will be made available at or by the facility at an extra charge;

[(20)] **(22)** if applicable, a statement that it is the provider's policy to impose a surcharge on some, but not all, subscribers because of a condition or circumstance that applies only to those subscribers and that the surcharge is not part of the entrance fee refund required under § 10-448 of this subtitle;

[(21)] **(23)** a description of the role of any resident association;

[(22)] **(24)** a description of the internal grievance procedure;

(25) IF THE PROVIDER OFFERS A CONTINUING CARE AGREEMENT THAT PROMISES A CONTRACTUAL ENTRANCE FEE REFUND AFTER OCCUPANCY, A STATEMENT WHETHER THE PORTION OF THE ENTRANCE FEE TO BE REFUNDED IS HELD IN TRUST OR ESCROW FOR THE SUBSCRIBER AFTER OCCUPANCY, AND IF SO HELD, A DESCRIPTION OF WHERE AND HOW THE FUNDS ARE HELD;

(26) IF THE PROVIDER OFFERS AN EXTENSIVE AGREEMENT, THE FOLLOWING STATEMENT: "IF YOU HAVE A LONG-TERM CARE INSURANCE POLICY, REQUEST YOUR ADVISORS TO REVIEW THE POLICY AND THE CONTINUING CARE AGREEMENT TO DETERMINE WHETHER THERE ARE POTENTIAL AREAS OF DUPLICATION OR AREAS WHERE BENEFITS CAN BE COORDINATED.";

[(23)] (27) a statement that the provider will amend its disclosure statement whenever the provider or the Department considers an amendment necessary to prevent the disclosure statement from containing:

(i) a material misstatement of a fact required by this section to be stated in the disclosure statement; or

(ii) an omission of a material fact required by this section to be stated in the disclosure statement; and

[(24)] (28) any other material information about the facility or the provider that the Department requires or that the provider wishes to include.

10-427.

(a) (1) If a provider has a governing body, at least one of the provider's subscribers shall be a full and regular member of the governing body.

(2) If the provider owns or operates more than three facilities in the State, the governing body shall include at least one of the provider's subscribers for every three facilities in the State.

(3) Subject to paragraph (4) of this subsection, a member of the governing body who is selected to meet the requirements of this subsection shall be a subscriber at a facility in the State and be selected according to the same general written standards and criteria used to select other members of the governing body.

(4) The governing body shall confer with the resident association at each of the provider's facilities before the subscriber officially joins the governing body.

(5) The Secretary may waive the requirements of this subsection for a provider in the process of decertifying as a provider, if the Secretary determines that there are no subscribers willing and able to serve on the governing body.

(b) (1) If a provider does not have a governing body, the provider shall appoint a select committee of its officers or partners to meet at least twice a year with the resident association at each of its facilities to address concerns of the subscribers and to ensure that the opinions of subscribers are relayed to all officers or partners of the provider.

(2) If a facility does not have a resident association, the committee shall meet with a reasonable number of representatives, not required to exceed fifteen, that the subscribers elect.

(C) AS DETERMINED BY THE PROVIDER'S GOVERNING BODY, THE PROVIDER SHALL MAKE AVAILABLE TO SUBSCRIBERS EITHER THE NONCONFIDENTIAL PORTIONS OF THE MINUTES OF EACH MEETING OF THE GOVERNING BODY OR A SUMMARY OF THE NONCONFIDENTIAL PORTIONS OF THE MINUTES, WITHIN 1 MONTH OF APPROVAL OF THE MINUTES.

10-428.

(a) A provider shall establish an internal grievance procedure to address a subscriber's grievance.

(b) The internal grievance procedure shall at least:

(1) allow a subscriber or group of subscribers collectively to submit a written grievance to the provider;

(2) require the provider to send a written acknowledgment to the subscriber **OR GROUP OF SUBSCRIBERS** within 5 days after receipt of the written grievance;

(3) require the provider to assign personnel to investigate the grievance;

(4) give a subscriber **OR GROUP OF SUBSCRIBERS** who [files] **FILE** a written grievance the right to meet with management of the provider within 30 days after receipt of the written grievance to present the [subscriber's] grievance; and

(5) require the provider to respond **IN WRITING** within 45 days after receipt of the written grievance regarding the investigation and resolution of the grievance.

(c) (1) Within 30 days after the conclusion of an internal grievance procedure established under this section, a subscriber, **GROUP OF SUBSCRIBERS**, or provider may seek mediation through one of the Community Mediation Centers in the State or another mediation provider.

(2) If a provider [or], subscriber, **OR GROUP OF SUBSCRIBERS** seeks mediation under paragraph (1) of this subsection:

(i) the mediation shall be nonbinding; and

(ii) the provider [and], subscriber, **OR GROUP OF SUBSCRIBERS** may not be represented by counsel.

10-429.

A provider shall make readily available to its subscribers for review at the facility:

(1) copies of all materials that the provider submits to the Department that are required to be disclosed under the Public Information Act; AND

(2) A COPY OF THE MOST RECENT FINALIZED BUDGET OF THE FACILITY.

10-430.

ALL MARKETING MATERIALS, INCLUDING DISCLOSURE STATEMENTS, THAT STATE THAT PART OR ALL OF THE ENTRANCE FEE IS OR MAY BE REFUNDABLE SHALL INCLUDE A CONSPICUOUS DISCLAIMER THAT STATES AT LEAST THE FOLLOWING: "CAREFULLY READ THE CONTINUING CARE AGREEMENT FOR THE CONDITIONS THAT MUST BE SATISFIED BEFORE THE PROVIDER IS REQUIRED TO PAY THE ENTRANCE FEE REFUND."

10-432.

(a) (1) [This section and §§ 10-433 through 10-435 of this subtitle do] **SUBSECTION (B)(2) OF THIS SECTION DOES** not apply to [a transfer of ownership of a facility, or] a transfer of ownership or control of a person that owns or controls a facility, if:

(i) the transfer is part of a business reorganization; and

(ii) the same person or persons holding **THE RIGHT TO CONTROL OR HOLDING** a majority of ownership [or right to control] before the business reorganization will retain, directly or indirectly, [a majority of ownership or] **THE** right to control **OR A MAJORITY OF OWNERSHIP, RESPECTIVELY,** after the business reorganization.

(2) The provider shall notify the Department and the facility's subscribers 30 days before any reorganization described in paragraph (1) of this subsection.

(b) Unless the Department approves the sale or transfer in accordance with §§ 10-433 through 10-435 of this subtitle:

(1) **EXCEPT FOR THE GRANT OF A MORTGAGE OR DEED OF TRUST TO AN UNRELATED THIRD PARTY,** a provider that holds a preliminary, initial, or renewal certificate of registration [or] **MAY NOT SELL OR OTHERWISE TRANSFER,**

DIRECTLY OR INDIRECTLY, OWNERSHIP OF A FACILITY OR ANY OWNERSHIP INTEREST IN A FACILITY; AND

(2) a person with an ownership interest in or a right to control the provider, through governing body appointments or contractual or similar arrangements, may not sell or otherwise transfer, directly or indirectly[:]

[(1)] , **THE RIGHT TO CONTROL OR** more than 50% of the [provider's ownership of a facility; or

(2) more than 50% of the ownership of or right to control] **OWNERSHIP OF** a person that owns or controls a facility.

(c) Any series of sales or other transfers described in subsection (b) of this section that occur in a 12-month period shall be aggregated for purposes of this section and §§ 10-433 through 10-435 of this subtitle.

10-443.

THE PROVISIONS OF PART IV OF THIS SUBTITLE ARE IN ADDITION TO, AND NOT IN LIEU OF, OTHER APPLICABLE LAWS.

10-444.

(a) Except as provided in subsection [(b)(23)] **(B)(25)** of this section, a requirement of this section does not apply to any continuing care agreement entered into before the effective date of the requirement.

(b) In a form acceptable to the Department, each continuing care agreement shall:

(1) show the total consideration paid by the subscriber for continuing care, including the value of all property transferred, donations, entrance fees, subscriptions, monthly fees, and any other fees paid or payable by or on behalf of a subscriber;

(2) specify all services that are to be provided by the provider to each subscriber, such as food, shelter, medical care, nursing care, or other health related services, including in detail all items that each subscriber will receive, and whether the items will be provided for life or for a designated time period;

(3) designate the classes of subscribers according to types of payment plans;

(4) subject to subsection (c) of this section, describe the procedures to be followed by the provider when the provider temporarily or permanently changes the subscriber's accommodations within the facility or transfers the subscriber to another health facility;

(5) describe the policies that will be implemented if the subscriber becomes unable to pay the monthly fees;

(6) state the policy of the provider concerning changes in accommodations and the procedure to implement that policy if the number of persons occupying an individual unit changes;

(7) provide in clear and understandable language, in boldface type, and in the largest type used in the body of the agreement:

(i) the terms governing the refund of any portion of the entrance fee if the provider discharges the subscriber or the subscriber cancels the agreement; and

(ii) whether monthly fees, if charged, will be subject to periodic increases;

(8) state the terms under which an agreement is canceled by the death of the subscriber;

(9) provide that charges for care paid in advance in a lump sum may not be increased or changed for the duration of the agreed-upon care;

(10) state that the **PROVIDER REPRESENTS THAT THE** subscriber has received, at least two weeks before signing the agreement[,]:

(I) the current version of the written rules of the provider;

(II) THE CONTINUING CARE AGREEMENT FORM, WITH THE ATTACHMENTS, EXHIBITS, AND ADDENDA; AND

(III) THE CURRENT DISCLOSURE STATEMENT, WITH THE ATTACHMENTS, EXHIBITS, AND ADDENDA;

(11) describe the living quarters;

(12) if applicable, state the conditions under which a subscriber may assign a unit for the use of another individual;

(13) state the provider's religious or charitable affiliations and the extent, if any, to which the affiliate organization is responsible for the provider's financial and contractual obligations;

(14) state the subscriber's and provider's respective rights and obligations concerning:

(i) use of the facility; and

(ii) any real and personal property of the subscriber placed in the provider's custody;

(15) state that subscribers have the right to organize and operate a subscriber association at the facility and to meet privately to conduct business;

(16) state that there is an internal grievance procedure to address a subscriber's grievance;

(17) state the fee adjustments, if any, that will be made if the subscriber is voluntarily absent from the facility for an extended period of time;

(18) specify the circumstances, if any, under which the subscriber will be required to apply for Medicaid, Medicare, public assistance, or any public benefit program and whether the facility participates in Medicare or medical assistance;

(19) state that the subscriber received a copy of the latest certified financial statement at least two weeks before signing the agreement and that the subscriber has reviewed the statement;

(20) STATE THAT THE SUBSCRIBER ACKNOWLEDGES REVIEWING ALL OF THE TERMS OF THE ENTRANCE FEE REFUND CLAUSES AND PROVISIONS CONTAINED IN THE CONTINUING CARE AGREEMENT;

[(20)] (21) provide that, on request, the provider will make available to the subscriber any certified financial statement submitted to the Department;

[(21)] (22) if applicable, describe the conditions under which the provider may be issued an initial certificate of registration and the conditions under which the provider may use escrowed deposits, and state the amount of the subscriber's deposit;

[(22)] (23) state that fees collected by a provider under the terms of a continuing care agreement may only be used for purposes set forth in the agreement;

(24) INCLUDE ONE OF THE FOLLOWING MODEL STATEMENTS OR A SUBSTANTIALLY SIMILAR STATEMENT:

(I) “THE PROVIDER AGREES THAT, FOR AS LONG AS THE SUBSCRIBER’S CONTINUING CARE AGREEMENT REMAINS IN EFFECT, THE PROVIDER SHALL ~~USE ONLY~~ ONLY USE FEES PAID BY THE SUBSCRIBERS OF THE COMMUNITY FOR PURPOSES DIRECTLY RELATED TO THE CONSTRUCTION, OPERATION, MAINTENANCE, OR IMPROVEMENT OF THE COMMUNITY.”;

(II) “THE PROVIDER DOES NOT CURRENTLY USE FEES PAID BY SUBSCRIBERS OF THE COMMUNITY FOR PURPOSES OTHER THAN THOSE DIRECTLY RELATED TO THE CONSTRUCTION, OPERATION, MAINTENANCE, OR IMPROVEMENT OF THE COMMUNITY, BUT THE PROVIDER RESERVES THE FUTURE RIGHT TO USE FEES PAID BY SUBSCRIBERS OF THE COMMUNITY FOR PURPOSES UNRELATED TO THE CONSTRUCTION, OPERATION, MAINTENANCE, OR IMPROVEMENT OF THE COMMUNITY.”; OR

(III) “THE PROVIDER MAY USE FEES PAID BY SUBSCRIBERS OF THE COMMUNITY FOR PURPOSES UNRELATED TO THE CONSTRUCTION, OPERATION, MAINTENANCE, OR IMPROVEMENT OF THE COMMUNITY, INCLUDING FOR THE FURTHERANCE OF THE PROVIDER’S CORPORATE MISSION, TO DISTRIBUTE PROFITS, OR TO BENEFIT AN AFFILIATED COMMUNITY.”;

[(23)] (25) allow a subscriber to designate a beneficiary to receive any refundable portion of the entrance fee that is owed due to the death of the subscriber on or after the date of occupancy, if the designation is:

- (i)** in writing;
- (ii)** witnessed by at least two competent witnesses;
- (iii)** not contingent; and
- (iv)** specified in percentages and accounts for 100% of the refund due;

[(24)] (26) state the funeral and burial services, if any, that the provider will provide; [and]

(27) CONTAIN A TABLE OF CONTENTS;

(28) IF THE PROVIDER OFFERS A CONTINUING CARE AGREEMENT THAT PROMISES A CONTRACTUAL ENTRANCE FEE REFUND AFTER OCCUPANCY, STATE WHETHER THE PORTION OF THE ENTRANCE FEE TO BE REFUNDED IS

HELD IN TRUST OR ESCROW FOR THE SUBSCRIBER AFTER OCCUPANCY, AND IF SO HELD, STATE WHERE AND HOW THE FUNDS ARE HELD;

(29) IF THE PAYMENT OF A CONTRACTUAL ENTRANCE FEE REFUND AFTER OCCUPANCY IS CONDITIONED ON THE REOCCUPANCY OR RECONTRACTING OF THE SUBSCRIBER’S UNIT, STATE THAT THE PROVIDER AGREES TO MAKE REASONABLE EFFORTS TO SATISFY THE CONDITION; AND

[(25)] **(30)** contain the following statement in boldface type and in the largest type used in the agreement: “A preliminary certificate of registration or certificate of registration is not an endorsement or guarantee of this facility by the State of Maryland. The Maryland Department of Aging urges you to consult with an attorney and a suitable financial advisor before signing any documents.”.

10–445.

(a) (1) (i) If a provider’s feasibility study has been approved under § 10–409 of this subtitle, the Department, within 120 days after receipt of a continuing care agreement or any other related agreement submitted by a provider, shall determine whether the agreement complies with the requirements of this subtitle.

(ii) At any time during the review process, the Department may submit comments to or request additional information from the provider to determine whether the agreement complies with the requirements of this subtitle **AND OTHER APPLICABLE LAW**.

(iii) If the Department submits comments or a request for additional information under subparagraph (ii) of this paragraph, the 120–day review period under subparagraph (i) of this paragraph is suspended.

(iv) On receipt of any requested information or modifications to the agreement necessitated by the Department’s comments under subparagraph (iii) of this paragraph, the Department, within the number of days remaining in the 120–day review period, shall:

1. complete its review to determine whether the agreement meets the requirements of this subtitle **AND OTHER APPLICABLE LAW IDENTIFIED BY THE DEPARTMENT IN ACCORDANCE WITH SUBPARAGRAPH (II) OF THIS PARAGRAPH**; and

2. approve or disapprove the agreement.

(v) 1. If the Department does not approve the agreement, the Department shall notify the provider in writing, including citations to the specific

provisions of law that the Department determined were not complied with in the agreement.

2. A provider may appeal the disapproval of an agreement under subparagraph (iv) of this paragraph under the provisions of Title 10, Subtitle 2 of the State Government Article.

(2) If the Department does not act within 120 days, the agreement is deemed approved.

(b) The provider shall maintain the continuing care agreement at the facility and make it available for inspection by the Department of Health and Mental Hygiene under Title 19, Subtitle 18, of the Health – General Article and Title 10, Subtitle 3 of the Health – General Article.

(c) If a provider is seeking approval for a modification to an approved continuing care agreement or other related agreement, the Department shall limit its review to:

(1) the section of the agreement being modified and any sections directly affected by the modification; and

(2) any section of the agreement that may have been affected by a change in the law or a regulation that was enacted after the Department approved the agreement.

[(d) If the provider executes a separate assisted living agreement or comprehensive care agreement, the provider is not required to submit the assisted living agreement or comprehensive care agreement or any requests for modifications to the Department for approval.]

(D) IF THE CONTINUING CARE AGREEMENT IS NOT AN EXTENSIVE AGREEMENT OR A MODIFIED AGREEMENT AND THE PROVIDER USES A SEPARATE ASSISTED LIVING AGREEMENT:

(1) THE PROVIDER IS NOT REQUIRED TO SUBMIT THE ASSISTED LIVING AGREEMENT OR ANY REQUESTS FOR MODIFICATIONS TO THE DEPARTMENT FOR APPROVAL; AND

(2) (I) THE PROVIDER SHALL STATE IN ITS CONTINUING CARE AGREEMENT THAT, IF THE SUBSCRIBER WISHES TO TRANSFER TO ASSISTED LIVING, THE SUBSCRIBER WILL BE REQUIRED TO SIGN AN ADDITIONAL SEPARATE AGREEMENT FOR ASSISTED LIVING SERVICES THAT WILL NOT BE APPROVED BY THE DEPARTMENT FOR COMPLIANCE WITH LEGAL

**REQUIREMENTS OR COORDINATION WITH THE CONTINUING CARE AGREEMENT;
AND**

(II) THE PROVIDER MAY INCLUDE A PROVISION IN ITS CONTINUING CARE AGREEMENT STATING THAT ASSISTED LIVING CONTRACTS AND SERVICES ARE REGULATED BY THE OFFICE OF HEALTH CARE QUALITY WITHIN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(E) IF THE CONTINUING CARE AGREEMENT IS NOT AN EXTENSIVE AGREEMENT OR A MODIFIED AGREEMENT AND THE PROVIDER USES A SEPARATE COMPREHENSIVE CARE AGREEMENT:

(1) THE PROVIDER IS NOT REQUIRED TO SUBMIT THE COMPREHENSIVE CARE AGREEMENT OR ANY REQUESTS FOR MODIFICATIONS TO THE DEPARTMENT FOR APPROVAL; AND

(2) (I) THE PROVIDER SHALL STATE IN ITS CONTINUING CARE AGREEMENT THAT, IF THE SUBSCRIBER WISHES TO TRANSFER TO COMPREHENSIVE CARE, THE SUBSCRIBER WILL BE REQUIRED TO SIGN AN ADDITIONAL SEPARATE AGREEMENT FOR COMPREHENSIVE CARE SERVICES THAT WILL NOT BE APPROVED BY THE DEPARTMENT FOR COMPLIANCE WITH LEGAL REQUIREMENTS OR COORDINATION WITH THE CONTINUING CARE AGREEMENT; AND

(II) THE PROVIDER MAY INCLUDE A PROVISION IN ITS CONTINUING CARE AGREEMENT STATING THAT COMPREHENSIVE CARE FACILITIES CONTRACTS AND SERVICES ARE REGULATED BY THE OFFICE OF HEALTH CARE QUALITY WITHIN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

~~SECTION 2. AND BE IT FURTHER ENACTED, That the Secretary of Aging and the Insurance Commissioner shall:~~

~~(a) (1) study the feasibility, and if feasible, the advantages and disadvantages of creating a guaranty corporation, interstate compact, or similar construct to protect the financial interests of continuing care subscribers in the event of a continuing care provider's insolvency; and~~

~~(2) report the results of the study to the General Assembly, in accordance with § 2-1246 of the State Government Article, on or before November 1, 2013; and~~

~~(b) (1) study the advantages and disadvantages of requiring periodic actuarial studies for fee for service contracts offered by continuing care retirement~~

~~communities, including the use of any other pricing models to determine long term obligations; and~~

~~(2) report the results of the study to the General Assembly, in accordance with § 2-1246 of the State Government Article, on or before June 30, 2013.~~

SECTION ~~2~~ 2. AND BE IT FURTHER ENACTED, That if any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of this Act which can be given effect without the invalid provision or application, and for this purpose the provisions of this Act are declared severable.

SECTION ~~4~~ 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2012.

Approved by the Governor, May 22, 2012.